			For State Registrar	State	of Maryland		artment rtificate			ınd M	ental Hyg	iene g. No 200	5	315	102
	Physical		Decedent's Name (First, Middle, I								2. Date of Deat	h		3. Time of	
	Physici /Medic		MARIE		HMUCK		T				SEPT.	26°, 2005		3:04	ам
	Examin	er	4a. Facility Name (If not institution, g		mber)		, ,		Location of			4c. County of		MORE	
	Formanal		HERITAGE CENT 5. Social Security Number 6.	Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birth	9		ace (State or	r Foreign
	Funeral Director		213-05-5229	1□M 2 X F	91	Yrs.	Months	Days	Hours	Min.	10 V . 12	2,1913 I	IAR	YLAND	
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside Cit	v Limits
	Aaryla f sho	ō		rimore			DALE							1 🗆 Yes	
	28a-	rect	10e. Street and Number	LIMONE		NODE	10f. Zip				1	0g. Citizen of Wha	it Count	ry?	
	h with	ai D	5024 BRIGHTL	EAF COU	JRT			2	1237			U.S.A	A .		
	ams ams	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.: orces?	S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,			
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ∏Yes If Yes, G Year or [ive		1 ☐ Yes 2	No	Specify:			Specify: V	ידאו	PΕ	
8	2 hour	ed t	15. Decedent's	Education			dent's Usua					16b. Kind of Busin			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23e or 28a-f show ent, Ita Medical Examaran must be molified at	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed, College ((Give life.	kind of wor DO NOT us	rk done d se retired,	furing most)	of workii	ng				
7	ed wit ygien yer th	Con	7			HOUS	EWIF	E			(=	DOMI	ST.	IC	
Maryland	I be fill ntal H ed oth	Be	17. Father's Name (First, Middle, La JOHN BOEHM	st)					CATI			Maiden Sumame) DTTERWE	CH		
Ž	should be and Mental semarked o	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a				City or Town, Sta		Code)	
	and 2 ; selth ar n 27 is ier trau		JEAN ALBRENT/	DAUGHTE	ER							SEDALE, N			7
ore,	of Hee		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Bomoval from		lace of Dispo emetery, crei	sition (Nam	ne of ther place	9)	C	ate	20c. Location - Cit	y or Tov	vn, State	
altimore,	Pages ment of the ent: If its ury or o		'4 □Donation 5 □Other (Spe		SAC	RED H	EART	OF	JESU	US 9	9/29/05	BALTIN	10RI	E,MAR	YLAN
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural; or Itams 23e or 28a-f show ampointent: other traumatic event, Ira Medical Exertainer must be rediffied at once.		21. Signature of Fundamental Lice Lice	ensee	house	1	Name and LLLY	ጼ	$z_{\rm ETL}$	FR 1	INC. FU ST.,BA	NERAL I	IOMI E, MI	E. 21	224
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ly one cause on	caused the death each line.	n. Do not ent			-					Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	201-0	nic.	11	car	1 2		Deas	4		7/11	
	/Medical Examiner		Todaking in dodan,	Due to	(or as a consequ	uence of):							(f	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a consequ	uence of):							+		
	cate be executed oblysicien and the burial-transit	Examiner	that initiated events	c											
8760,	be execten a		resulting in death) Last	Due to	(or as a consequ	ience of):									
687	icate be ex physicien s the buria	adica		d											
Box (death certificate be executed e attending physicien and od for use as the burial-transit	In/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnar		Ectopic pr	oonana.				23d. Date o	f deliver	-	
). B	ne deat the att	Physician/Medical	in the past 12 months?		nant at time of de		Other (sp					Month	1	Day Y	ear
P.O.	The law requires that the de the has been signed by the bage 2 should be detached		9 ☐ Unknown Part II. Qther significant conditions	contributing to c	leath but not sesu	ufting in the u	nderlying ca	ause give	en in Part I.		23e. Did tob	acco use contribe	te to the	e cause of de	eath?
Vital Records,	uires t signe Id be	d by	(herist	rend	Va	csa	lus	L	C. 20	cos	. 1 ☐ Ye	s 2 No 3[Proba	ıbly 4 ∏Uı	nknown
COL	w requires been si	lete	Della de	MI	1 m						24a. Was ar	1 24b, Wer	e autop	sy findings a	vailable
Re	icien: The la certificate has rector, page 2	Completed	Dadis	i c	Nh	· cc	un				autops perform	ned? dea	r to com th? Yes 2	pletion of ca 2 □ No	use of
ita	ien: artifica ctor, p	Bec	25. Was case referred to medical examiner?		8				26. Place	of Death	(Check only one				
of <	Physic this ce al dire	ို	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 Nul	rsing Hor		nce 6 Other (Specify))	
ou c	ding P h. After funera	ion	27. Manne of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	f 2	8c. Injury Work	at (? /es 2.∐N		28d. Describe no	w injury occurred			
Division	f or Attendi after death. Director: A i in by the fu	ficat	2 Accident investigat 3 Suicide 6 Could not determine	be 28e. Plac	e of Injury - At ho	me, farm, str					28f. Location (Str	reet and Number o	r Rural	Route Numb	per,
ă	s after of Direct	Certification;	4 Homicide	build	ling, etc. (Specify	/)					City or Town	, State)			
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h. completely lifled in by the funeral director, page	edical C		aminer: On the t								use(s) and manne ate and place, and			
	To the within To the comp	Me	29b. Signature and title of certifier	1	. 2		29c	License	number		29	od. Date signed (A	fonth, D	ay, Year)	
	of		1 yper oc		- · H(1)			yo.	oos	35	8	sept 2	6	200	
8	\ \		30. Name and address of person wh	V.	PAT	121	Print)	8	903 BA	4	ART	ORD	120	2/2	230
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 8	2005	Registrar's Signal	ture	foods	,	VIL						

muel Lee Shufford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 23, 2005 **Physician** 1:40 P M Samuel Lee Shufford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2040 Ruxton Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F 213-52-8181 Director 58 11-27-1946 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State in than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 2040 Ruxton Avenue 21216 USA filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Organist or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Falher's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event once. Be Samuel Lee Shufford Sr. Ethel Mae Brice ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl Shufford / Son 2814 Montebello Terrace Balto, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 10-01-05 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Kenula Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Injerval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) force upries Physician blunt Muitale /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Completed by Physician/Medical the as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the el d be detached fo ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed? 24b. Were aulopsy findings available prior to completion of cause of death?

1 → es 2 □ No certificete Yes 2 No To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCENE XXYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury Month, Day Year) 28c. Injury at Work? 27. Manner of Death subject assouted 1 Natural 5 Pending 1 ☐ Yes 2 🕅 No death. investigation 1:30P M 23 2005 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Bull more 2040 RUX An Ave home To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 24, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Circe

31. Date filed (Month, Day

32. Alegistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 200531504 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SFPT. **Physician** 2005 25 SALIK 9:45 A **FELICIA** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner BALTIMORE** N/A 4000 N. CHARLES STREET APT. #1502 If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 12/08/1914 5, Social Security Number Funeral 1 □ M 2 X F UNKNOWN 90 Director 124-20-1528 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!" ~ " any injury or other treumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Completed by Funeral Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4000 N. CHARLES STREET APT. #1502 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ENOCH PRATT LIBRARY LIBRARIAN 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3635 OLD COURT ROAD SUITE # 201 BALTIMORE, MD 21208 MORRIS FIDDLE/ATTORNEY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 09/27/2005 TOWSON, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 002 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 \linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Residence 6 Other (Specify) 7 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel 5 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) who completed cause of death (kem 23a) (Type, Print) OWEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	aryland / De	epartmen C <i>ertificati</i>	t of H e <i>of L</i>	lealth and l D <i>eath</i>		giene 005	31505
	Physici	an	1. Decedent's Name (First, Middle, La	TI					2. Date of De	ath Day Ye	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	homil	۶	4h City	Town or	Location of Death	09	23 0	10:18 FM
	Examin	er	/	Care Cente		4D. City,	13-	Home Coall	1	4c. County of I	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birth	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9.	Birthplace (State or Foreign Country)
	Director		212-30-8899 Usual Residence of Decedent	□M 2kgF	_80 ^{YI}	S.			11-15		S.C.
	yłand how		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Ba-1 s	ector	Md.	NA	В	altimor	е				Yes 2 No
	with the a or 2	Dire	10e. Street and Number 2774 The Alemeda			10f. Zip		218		10g. Citizen of Wha	t Country?
	death ms 23	Funeral Director	11. Marital Status	12. Was Decedent 8	ver in U.S.	13. Was Deced	lent of Hi	spanic Origin? (Si	pecify Yes or No		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	if Yes, spec		n', Mexican', Puèrto Specify:	Rican, etc.)	Specify: E	White, etc. Black
5-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. D	ecedent's Usua Give kind of wor	l Occupa k done d	ition luring most of worl	king	16b. Kind of Busin	ess/Industry
712	s withir piene. r than	omo	Elementary/Secondary (0-12) 6th grade	College (1-4or 5	+)	urses A		,		Daniel and B	1 - 3 - OL -
	al Hyg al Hyg i othe	Be C	17. Father's Name (First, Middle, Last)			urses A.	10	18. Mother's Nam	e (First, Middle,	Bayview Maiden Sumame)	lea Ctr.
yla	Ment Ment Parkec	2	Joe		ster			Unkn			
Maryland	id 2 sh Ith and 27 Iann traum		19a. Informant's Name/Relationship (Willie Jones	Type, Print) Son				Ave., Ba		er, City or Town, Sta	
re,	s 1 ar of Hea itam ;		20a. Method of Disposition		20b. Place of D		na of		Date	20c. Location - City	
Baltimore,	Pages ment of I ant: If its lury or o		1 Burial 2 Cremation 3 C 1 Other (Specification	<i>(</i>)		Mem. Pk		9–29-	-05	Randalls	stown, Md.
Ball	permit. Depart Import any inj		21. Signature of Funeral Service Licer	see		22. Name and March		1		more, Md. E. North A	
	£		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	enter the mode	e of dying	, such as cardiac			Approximate Interval Between
	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	a. end	Stage 1	inal dis	une				Onset and Death
١	Examiner		- 1		consequence of	melle	the				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	:	-				
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of)						
68760,	ficate be executed g physician and is the burial-transit	edical E	l	d							
68			IF FEMALE:								
80	w requires that the death certif been signed by the attending should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal death	3 Ectopic pre				23d. Date of Month	delivery Day Year
o.	the de	hysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown	ime or death	5 Other (spe	эсігу)				
s, D	es thai gned b	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	ne underlying ca	use give	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ord	requir		gangrene				-		1 🗆 Y	′es 2□No 3□	Probably 4 Unknown
al Rec	Phyaician: The law this certificate has t al director, page 2 s	Completed						 	24a. Was autop perfor 1 Yes	sy prior	
<u>;;</u>	aician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	26. Place of Deat			
1 0	ig Phy ter this neral d	-	27. Man of Death	28a. Date of Injury (Month, Day	t 2 ☐ ER/Outpa / 28b. Tirr / Year) Inju	e of 28	Bc. Injury Work	at		lence 6 Other (S	Specify)
Sion	tandin eath. ior: Af the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2 No			
Div	tal or At rs after d al Diract ed in by	Certification:	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm (Specify)	, street, factory,	office		28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or Attanding Physician: The law requires that the death certivitin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medicai	29a. Certifier (Check only one)	ysician: To the best or liner: On the basis of and manner stat	examination and/o	eath occurred a r investigation,	it the time in my opi	e, date and place, inion, death occur	and due to the o	cause(s) and manner date and place, and c	r as stated. due to the cause(s)
	To To t	Σ	29b. Signature and title of certifier				License		1	29d. Date signed (Me	
F	d	-	30 Namo and addings (30 Namo	completed cover of the	ath (lta= 00-) =		005			01/25/0	8
9			30. Name and/address of person who	no 70	ath (Item 23a) (Ty 2 W. Y ('s Signature	pe, Print)	٥٦	ha. Hork	im at tes	mik F	3a / timore mo 21210
	Stat	ę	31. Date filed (Month, Day, Year) SEP 2 8	32. Registra	r's Signature	P	-	110			The Man Man Man

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Agnes Hall 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Huspital (enter arroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2♥F Yrs 21270729 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Neulcal English et notified any injury or other traumatic event, the Neulcal English et notified and 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits SYKESUILLE 1 ☐ Yes 2 No MO CARNOLL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BUSHEY ROAD 21784 5100 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TABLER, INC. EALTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LYDIA Viola LAYMAN CHARLES HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 BUSHEY ROOW SYKESVILLE MO SON Robert L. TABLER, VR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) EVERGREEN MEM. GAR. 10/1/2005 FINKSBURG, MO 22. Name and Address of Facility JN ZUMBMN F. H & MON CO of Funeral Service Licensee 21. Signature 1060 N.3 umbrun 6028 SYKESVILLE ROAD ELDERSBURG MO 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate tnterval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE PULMONARY DISEASE CHRONIC **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Tany, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jua to (or as a nonsequence of): Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 DQA Certification: To this 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 5 the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09-27-05 30263 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) CARROLL HOSPITAL CENTER

Registrar

State

OBI

KHOO, MD

32. Registrar's Signature

TAT-TEE

FRANCIS

31. Date filed (Month, Day, Year)

200 MEMORIAL AVENUE, WESTMINSTER, 2115-

1. Decedent's Name (First, Middle, Last) Physician Albert /Medical 4a. Facility Name (If not institution, give street and number) Examiner **Funeral** Director 10a. State

E.

Thompson

27 is marked other than "natural", or iteme 23a or 28a-f show traumetic event, the Maclical Examinar number partitled at 12 should be filed within 7/ h and Mental Hygiene. 7 is marked other than "n permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is eny injury or other trau once.

Physician /Medical Examiner

attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a certificate director, this After thi funeral of hours after death. meral Director: Att y filled in by the fun within 24 hours a

Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 11, 1923 5. 20cial Security Number 6. Sex 1X M 2 ☐ F 9. Birthplace (State or Foreign Months Days Hours MaryTand 212-20-4529 82 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Baltimore Director Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10937 Mays Chapel Rd. 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Broadway Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Eccleston Thompson, Sr. Edwina Hanlon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Thompson/ Daughter 11820A Mays Chapel Rd. Lutherville, Md.21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Aburial 2 Commation 3 Removal from State Dulaney Valley Mem. 9-29-05 Timonium, Md. 21. Signature of Funeral Service Licenses RUCK 1050 Towson Faritineral Home, York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NIGocardia tarction 30 minutes disease or condition resulting in death) Due to (or as a consequence of) Cardiovasen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 \ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Implementation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date igned (Month, Day, Year) 20650 26 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David Collins, MD. 6701 N. Charles St. #4101 Baltimore, Md. 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per inf 2848 10-12-05 vt.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.2 U 0 5

4c. County of Death

10:45am

Day

September 24, 2005

2. Date of Death Month

DHMH 17 Rev 1/2001

State

Registrar

David Collins, MD.

SEP 2 8 2005

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			For	State of Maryland / D	epartment of	Health and M		
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death	Reg.	
	Physici						Month	Day Year 3. Time of Death 2. 17 2005 10:55 2
	/Medic Examin		Randolph Thomas 4a. Facility Name (If not institution, give s		4b. City, Town,	or Location of Death	eptembe	4c. County of Death
	2XIIII		Sacred Heart Ho	me	Hyatts			Prince George's
	Funeral Director		5. Social Security Number 2 1 7 - 3 2 - 1 5 3 0 Usual Residence of Decedent	7. Age (In yrs. last birth 75 Y	Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye une 8 1	9. Birthplace (State or Foreign Country) Maryland
	ow or		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	a-f sh	ctor	MarylandPrince G	eorge's Upper	Marlbor	0		1 ☐ Yes 2 ANO
	vith the	Dire	10e. Street and Number	01	10f. Zip Code 20772	3		Citizen of What Country?
	eath v	erai	3004 South Grove	12. Was Decedent Ever in U.S.				USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 is marked other than "natural", or Items 23a or 28a-1 show may injury or other traumatic event. The Modical Examinant must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Xiovorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	If Yes, specify Cut 1 ☐ Yes 2 No	Hispanic Origin? (Spector) Dan, Mexican, Puerto For Specify:	Rican, etc.)	Black, White, etc. Specify: Black
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. I	Decedent's Usuat Occu	pation during most of working	168	p. Kind of Business/Industry
12	within ane. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done life. DO NOT use retire taff Assi			S Capital
0	filed Hygie Dthar I		10th 17. Father's Name (First, Middle, Last)	0 5	COLL MISSI	18. Mother's Name		
au	Mental rked o	To Be	William Thomas			Eugenia		
Maryland 21215-0036	1 and 2 should i Health and Meni em 27 is marken ther traumatic		19a. Informant's Name/Relationship (Type Rammy R. Thomas (ity or Town, State, Zip Code)20721 tchellville, Md.
altimore,	Pages 1 annount of Hermant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State 20b. Place of l	Disposition (Name of crematory or other pla	9-27-	0.5	c. Location - City or Town, State
<u>=</u>	artmen artmen ortant: njury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Cremator	Y	13.0	altimore, Md.
Ba	Dermi Oepa Impo		Harry 17.	Leese				má. 21401
В	W 11		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ot enter the mode of dy	ing, such as cardiac or	respiratory arrest.	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Sepsis Due to (or as a consequence of	n):			
	Examiner		Sequentially list conditions	Pneumonia				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events	Due to (or as a consequence of	·):			
	xecut and	хап	that initiated events resulting in death) Last	Due to (or as a consequence of	·):			
760,	ate be executed hysician and the burial-transit	ical E						
68	rtificat ng phy as th	Medi	IE ECMAI E					
Box	death certificate be executed e attending physician and nd for use as the burial-transit	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnanc	>y		23d. Date of delivery Month Day Year
o.	at the dea by the a tached f	Physician/Med	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			Month Day Toal
Δ.	ss tha	by Ph	Part II. Dther significent conditions con		, , ,	ven in Part I.	23e. Did tobace	co use contribute to the cause of death?
Records,	w require been sig should b	ted	Hypertensive Ca		sease		1 Tes	2 No 3 Probably 4 Unknown
Sec	The law cate has b page 2 st	Completed	Diabetes Mellit				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	ician: Th certificate rector, pag	e Col	Peripheral Vaso	ular Disease			1 ☐ Yes 🗶 ☐	
5	ysician: is certific director,	0 B	25. Was case referred to medical examiner? 1 Yes X No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Ot	26. Place of Death		e 6 ☐Other (Specify)
100	ding Phy th. After thi funeral	n: T	27. Manner of Death	28a. Date of Injury 28b. Tii		ry at 2	Bd. Describe how i	
S	uttendir death. ctor: Al y the fu	catic	1. Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1	Yes 2□No		
Division of Vital	after d Direct Jin by	Certification:	4 Homicide determined	28e. Place of thiury - At home, farm building, etc. (Specify)	n, street, factory, office	2	Bf. Location (Street City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) (Check only one)	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occurred at the ti	me, date and place, ar opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. Licen	se number	29d.	Date signed (Month, Day, Year)
		/	1 axul	ez, mo m	D 00!	51122	9-	23-05
1	NY		30. Name and address of person who con Dr. Juanitez 1	nploted cause of death (Item 23a) (T 160 Varnum St.		te 008 W	ashingto	on D.C. 20017
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 8 20	32. Registrar's Signature	Leady			
	1.091311	1	DET 6 0 41	All a strategic of the	The state of the s			

Va	Baltimore, Maryland 21215-0036	permit Pages 1 and 2 should be filed within 72 hours after c bepartment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.
	Division of Vital Records, P.O. Box 68760,	dospitel or Attending Physicien: The law requires that the death certificate be executed to hours after death. When the Director: After this certificate has been signed by the ettending physician and the properties of the physician and the physician and the properties of the physician and the physi

ician	Registrar 1. Decedent's Name (First	t, Middle, Last)				ificate of I	Journ	2. Date of Dea		5 3 1 5 C
dical	Lillie Vaug	h n						Septen		7:16 F
niner.	4a. Facility Name (If not in			·	4	1 11	Location of Death		4c. County of [Death
al or	5. Social Security Number 242–09–7872	6. Sex		(In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Da) 11-03-19	y, Year)	Birthplace (State or For Country) ennsylvania
	Usual Residence of Deceded 10a. State 10b.	dent County		10c. City, Town	n or Loca	ition				10d. fnside City Lin
Director	MD	NA]	Balti					1X Yes 2□
	10e. Street and Number 5514 Wayne Av	7070110				10f. Zip Code 2120	77		10g. Citizen of Wha	it Country?
by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 X	Married	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1		ispanic Origin? (Spanic Origin? (Spanic Origin? (Specify:	pecify Yes or No- Dican, etc.)		American Indian, White, etc. Black
eted		ecedent's Educ ly highest grade		16a.	Deceder	nt's Usual Occup	ation during most of work	sin g	16b. Kind of Busin	ess/Industry
Completed	Elementary/Secondary		Coflege (1-4or 5	+)	Dome.	O NOT use retired	1)		Ho	omes
Be Co	17. Father's Name (First,	Middle, Last)			DOME	SCIC	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	лисы
To B	Robert Dicke	ns					Li	llian Dick	cens	
	19a. Informant's Name/Re	elationship (Typ	oe, Print)		_				ar, City or Town, Sta	ite, Zip Code)
once. To Be Completed by	Shirley W. Ric 20a. Method of Disposition 1 XBurial 2 Crer	n mation 3 ⊟Re		20b. Place of cemeter	f Disposit ry, crema	tion (Name of tory or other place		Date	20c. Location - Cit	
	4 Donation 5 C		Θ	Arbutus		morial Par Name and Addre		-05 [Baltimore, N	עוני
a) du	1			Wy1	ie Funeral	L Home 638 1	N. Gilmor	St. Balto,	MD 21217
a dical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last	ns, b c.	Due to (or as	a consequence	of):	10n				
/We	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 □ Yes 2 □ No 9 □ Unknown	nant	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death		ictopic pregnancy Other (specify) _	,		23d. Date o Month	of defivery Day Year
nysician/Medica	0 2 0 11111 10 1111		tributing to death bu	it not resulting in	n the und		en in Part I.	23e. Did to		te to the cause of death
by Physi	Part II. Other significant	conditions con				lerlying cause giv		101	/es 2□No 3[
pieted by	Part II. Other significant					lerlying cause giv		24a. Was autop perfo 1 🗆 Yes	an 24b. Wer prio dea 210 no 1	r to completion of cause
pieted by	Part II. Other significant 25. Was case referred to examiner?	madical	ospital: 1 □ Innatie	2 PFR/01		Oth	26. Place of Dea	24a. Was autop perfo 1 ☐ Yes	an 24b. Wer prio dea 1 □	r to completion of cause th? Yes 2 \(\text{No} \)
pieted by	Part II. Other significant 25. Was case referred to examiner? 1 □ Yes 2 □ No 27. Manner of Death 1 □ Natural 2 □ Accident	Pending investigation	ospital: 1 □ Inpatie 28a. Date of fnjur (Month, Day	y 28b. 1		3□ DOA Oth	er: 4 Nursing H	24a. Was autop perfo 1 Yes th (Check only o	an 24b. Wer prio dea 210 no 1	r to completion of cause th? Yes 2 \(\text{No} \)
pieted by	25. Was case referred to examiner? 1 Yes 2 Nanner of Death 1 Natural 5 2 Accident 3 Suicide 6 Homicide	Pending investigation Could not be determined	1 ☐ Inpatie 28a. Date of fnjur (Month, Day 28e. Place of Injubuilding, etc.	y Year) 28b. 1 Iry - At home, fa	utpatient Time of Injury	3 DOA Oth 28c. Injur Wor M 1 Det, factory, office	er: 4 □ Nursing H y at k? Yes 2 □ No	24a. Was autor performent of the Check only of the Check on the Check on the Check on the Check of the Check o	an state) 24b. We prio dea 1	Yes 2 No (Specify) or Rural Route Number,
pieted by	25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one)	Pending investigation Could not be determined	28a. Date of fnjur (Month, Day) 28e. Place of Injur building, etc. sician: To the best of the control on the basis of and manner sta	y Year) 28b. 1 ury - At home, fa (Specify) of my knowledge examination an	utpatient Time of Injury arm, stree	3 DOA Oth Wor Wor M 1 Det, factory, office occurred at the tire stigation, in my control of the stigation of	er: 4 Nursing H y at k? Yes 2 No me, date and place	24a. Was autor performent of the Check only of the Check on the Ch	an properties of the propertie	or to completion of cause th? Yes 2 No (Specify) or Rural Route Number, er as stated, d due to the cause(s)
To Be Completed by	25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one)	Pending investigation Could not be determined	28a. Date of fnjur (Month, Day) 28e. Place of Injur building, etc. sician: To the best of the control on the basis of and manner sta	y Year) 28b. 1 ury - At home, fa (Specify) of my knowledge examination an	utpatient Time of Injury arm, stree	3 DOA Oth Wor Wor M 1 Det, factory, office occurred at the tire stigation, in my control of the stigation of	er: 4 Nursing H y at k? Yes 2 No me, date and place	24a. Was autor performent of the Check only of the Check on the Ch	an properties of the propertie	or to completion of cause th? Yes 2 No (Specify) Or Rural Route Number, er as stated, if due to the cause(s)

			For State Registrar	State of Mary		artment of			Reg	ne No20	05	315	10
	Physici	an	1. Decedent's Name (First, Middle, Last) Robert Gibson	Vivian C	*				Date of Death Month eptember	Day 22	Year 2005	3. Time of D	eath \mathbf{P}^{M}
,	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town	n, or Location of		-premoer		y of Death	5:15	
	-Admin		Northampton Manor	Nursing Ho	me	Frede	rick			Fre	ederio	k	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Ye Months Da		24 Hrs. 8. Min.	Date of Birth (Month, Day, Y ecember 9	'ear)	9. Birthp	place (State or F	oreign
H	Director		Usuel Residence of Decedent		83 Yrs.			De	ecember 9,	, 1921		Arizo	na
	yland now		10a. State 10b. County	10	c. City, Town or Lo	ocation					1	0d. Inside City	Limits
	a-fsh	ctor	Maryland Frederic	k	Freder	ick						1 X Yes 2	□No
	or 28	Dire	10e. Street and Number			10f. Zip Cod			10g	. Citizen of	What Cour	ntry?	
	s 23a	eral	200 East Sixteenth	Street 12. Was Decedent Ever	10		701	ining (Consider	Vaa as Na		S.A.	an Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or Items 23a or 28a-7 show any injury or other traumatic event, it is Medical Examiner, just be inclifed at ODGE.	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Amed Forces? 1 → Yes 2 □ No If Tes, Give Year or Dates: Wh		Was Decedent of If Yes, specify C 1 ☐ Yes 2 🕱 I			an, etc.)	Bla	ck, White, fy: Whi	etc.	
5-0036	2 hou	ted	15. Decedent's Educ	eation	16a. Dece	dent's Usual Oc			16	b. Kind of E	Business/In	dustry	
215	thin 7 e. an 'n	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work do DO NOT use re	ine during mos tired)	t of working					
2121	led wi			4	Ent	reprene		- d- N1 /5			al Es	tate	
aryland	ould be fi Mental H arkad ot atic evar	To Be	17. Father's Name (First, Middle, Last) Charles Smiley Vi	vian				therin	First, Middle, Ma .e	Gib	•		
Jan	2 sho		19a. Informant's Name/Relationship (Ty)						Route Number, C	*	-		
e)	1 and Health am 27 thar t		Robert G. Vivian I		Ob. Place of Dispo	sition (Name of		I, PO Bo	ox 285, Je	c. Location	_		.755
timore,	ages int of I t: If it: y or o		1 ☐ Burial 2 X Cremation 3 ☐ R	emoval from State	cemetery, crea Smi.thsburg	matory or other	place)		1,1				٠,
altin	nit. P artme ortan injun		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			2. Name and Ad)9/24/ by	2005 5			Maryla Church S	
m	Der Imp		P. Kyan M	E Millian	> Ke	eney and	Basford	P.A. Fo	meral Hon			k, MD, 21	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Brain Can Due to (or as a co	cer	er the mode of	dying, such as	cardiac or re	espiratory arrest		1	Approximate Interval Betwe Onset and De Months	en uth
	Examiner	ıer	Sequentially list conditions, if any, leading to immediate	·									
	icuted nd iransit	Examiner	cause. Enter Underlying that initiated events	·									
8760,	cate be executed oblysician and the burial-transit	cal Ex	resulting in death) Last	Due to (or as a co	nsequence of):								
Ö	ortifica ing ph e as th	Med	IF FEMALE:										
P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p. 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregna Other (specify					ate of delive onth	ory Day Yea	r
Division of Vital Records, P.	quires that n signed by	þ	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause	given in Part I.		23e. Did tobac	2 XNo		ne cause of dea ably 4 □Unk	
CO	aw requir is been si 2 should	Completed							24a. Was an	24b.	Were auto	psy findings ava	ulable
æ	The la	Eo						:	autopsy performe 1 Yes 2		prior to condeath?	inpletion of cau: 2□ No	e of
Ita	Attending Physician: The law r death. r death. sctor: After this certificate has I by the funeral director, page 2 s	Bec	25. Was case referred to medical examiner?				26. Place	of Death (C	Check only one)				
7	Shysic this co	은	1 ☐ Yes 2 🗙 No		2 ER/Outpatier	IL 3D BOX			5 Residenc			1)	
L C	Jing F	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o Injury	1	njury at Work? I □ Yes 2 □ I		I. Describe how	injury occur	rred		
<u>ISI</u>	or Attending after death. Diractor: After in by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, str				. Location (Stree	et and Num	ber or Rura	l Route Number	
2	- 0	Certification:	4 Homicide determined	building, etc. (S	(pecify)	,			City or Town, S	State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		icien: To the best of more: On the basis of exa	amination and/or in								
	To th within To th comp	₩/	29b. Signature and title of certifie	1/1			ense number		29d.	Date signe	ed (Month, i	Day, Year)	
}	N) Idle			1	1264	99		9-2	3-0	5	
	10		30. Name and address of person who co			Print)							
	10	N.T.	Ronald Miller, MD,			t. Airy	y, Mary	land,	21771				
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's		200							
DH	MH 17 Rev 1/2		SEP 2 8 2005	Mayer	Is Apr								

Amend Please Type of Print in Black lade lible / lok / Danie All Copies Are Legible.

Amend Item 25 State MENOS PARTITION of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30, Walker August 2005 6:45a Clara Virginia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 207 Stan Lake Road Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 2, 191 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 K F Vrs 88 1917 Director 220-07-2917 May Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 207 Stan Lake Road items 23g 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify: by 3 ☑ Widowed 4 ☐ Divorced White "neturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Traffic Records MVA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Levering 2 Stella. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Lillian Aristidou Daughter 38 S Ritters Lane Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F
Importent: If ite
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park Sept 3, 2005 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road hon ELINE FUNERAL HOME Reisterstown , Maryland 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Assertio Physician Presmonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed CATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day ō Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 250 P 1 Yes this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred . After Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the f 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funerel C
completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 027123 130105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) una -Reiste 25 31. Date filed (Month, Day, Year) 32. Registrer's Signature State AUG 3 0 2005 Constant . Registrar

Physician /Medical Examiner

for use as the burial-transit

the attending physicien

cete has been signed by I page 2 should be detach

After this certificate has

funeral director,

the efter death Director:

filled in by

Be

Hospital or Attanding Physician:

death.

To the Hospital within 24 hours a To the Funeral Completely filled in

X

68760

Division of Vital Records, P.O.

WILLIAMS

SENJAM IN

permit. Pages 1
Depertment of He
Important: If Iten
any injury or oth

Funeral

Director

28a-f ahow

ŏ

or Itema 23a

ges 1 and 2 should be filed within 72 hours after to Heelth and Mental Hygiene. If Item 27 te marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

traumatic avant, the Medical Examiner must be notified at

the Maryland

death

PNEUMONECTOMY

24a. Was an autopsy performed 2 No 1 Yes

26. Place of Death (Check only one)

24b. Were aulopsy findings available prior to completion of cause of death? 2 310

25. Was case referred to medical 2 No 1 Yes 27. Manner of Death

Hospital: 1 Impalient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28b. Time of Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifie (Check only

t Matural

2 Accident

3 ☐ Suicide

4 Homicide

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

2 ER/Outpatient

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signalure and tille of certifier

MURTAM KAZMI, NID

P-17610

29c. License number

29d. Date signed (Month, Day, Year)

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAZILLI, MULTAZIA 31. Date liled (Month, Day, Year)

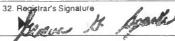
ST AGNES HOSPITIAL 900 CAYON AVE.

BALTIMORE MD

SEPTEMBER 24

State Registrar

SEP 2 8 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#26, perMD, 9847, 9/28/05 11
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1 Decedent's Name (First Middle Last) Day Month Vaar **Physician** 1:20 PM September 25, White Mack Clayton 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 € M 2 🗆 F Yrs. Aug. 24,1958 Maryland Director 213-72-5886 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "natural", or Itams 23s or 28s-f show traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Dundalk Maryland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 1912 Penhall Road United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. ant: If Itam 27 is marked other than "naturel; or Itar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify: Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Painter 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rose Hursey Stoney White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) Mrs. Rose Hardin (Mother) 1903 Guyway Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Depertment of important: If any injury or once. Hilltop Service Corp. 9/27/2005 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Uda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Ent the disease, or complications that caused the dividishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien end tor use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Yes 2 No 3 Probably 4 Unknown certiticate has baen si rector, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No Hospitel or Attanding Physician: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospitaf: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 6 Other (Specify) 1 ☐ Yes 2 No ၉ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manper of Death Certification: 1 Natural 2 Accident 5 Pending investigation s after de. 1 Tes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, dealy occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or revestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the state of the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ٥ 133551 Sept. 26, 2605 DAIR RO #314 BAHIMME 2123-30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

MICHREL FUERBACH, 9110 Philips THERBACK

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend item# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, PII, 9847, 9/28/05 IT State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registra Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Albert Walters 6:45 P M 24, 2005 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ivy Hall Geriatric & Reh. Ctr. Middle River Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1**X** M 2□ F Yrs **Director** 85 12,1920 North Carolina 241-22-1408 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Directo Maryland Dundalk Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examinar must be 21222 United States 3407 Yorkway Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? WWT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status WWII 1X Yes 2 No If Yes, Give 1942-45 Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 8 Years Pipefitter permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Lewis William Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland 3407 Yorkway 21222 Mrs. Effie I. Walters (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Other (Specify) 1 4 Donat Acred Ht. of Jesus Cem. 9/28/2005 Dundalk, Maryland Fy eral Sevice 21. Signaure 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acure eno Physician /Medical **Examiner** Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown as been si 2 should l 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 No page 1 ☐ Yes Division of Vital ths Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral C l 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AALICA WIELM . 709-MD-21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiena 1 - For State Registrar 31515 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day **GABRIELLE** 25, 200⁵ 4c. County of Death 3:20 P.M /Medical September 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Presbyterian Home of Maryland Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 💢 F Director 1920 Pennsylvania 215-16-1218 85 20. Feb. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
snt: if Item 27 is marked other than "natural; or Items 23a or 28a-f show ury or other traumatic event, it a Medical Examinat must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Ct. Completed by Funeral 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 vears Newspaper Reporter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Wise Donnallv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ira Gansler (Personal Rep.) 100 Light Street Baltimore, Maryland 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: if any injury or once. 9-28-05 Green Mount Crematory Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Y ear 4☐Pregnant at time of death Day signed by the et 5 Other (specify) 9 Unknown 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 (No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 b ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 TYes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Siper 26, 2005 30433 e of death (Item 23a) (Type ST BYTIMORE 6701 N CMMUS 31. Date filed (Mo. istrar's Signature State 2005 Registrar

nysicia	an	1 - State Registrar 1. Decedent's Name (First, Middle, Las. Marie C. Wirth)						2. Date of Dea Month eptemb	Day	6 200	
Medic xamin	-	4a. Facility Name (If not institution, give	street and number)			4b. City, To	wn, or Loca	tion of Death	ehreiiin		County of D	
, airiii		Pickersgill, Inc.				Towso					ltimo	
neral ector		5. Social Security Number 6. Security Number 10 Sec	X 7. Age	e (In yrs. BB	last birthday) Yrs.	If Under 1 \ Months D	ear If U	urs Min.	B. Date of Birt (Month, Da pr. B,	v. Year)	9. 7 Ma	Birthplace (State of Country) aryland
4		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside C
diffied	ctor	MD Baltimore	2	Tou	son							1 🗆 Yes
Dens	Funeral Director	10e. Street and Number 8304 Carrbridge C	irala			10f. Zip Co	de			10g. Citi: USA	zen of What	Country?
E COMME	nera	11. Marital Status	12. Was Decedent B	Ever in U	.S. 13. V		of Hispani	c Origin? (Spec xican, Puerto R				merican Indian,
event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🐼 N If Yes, Give Year or Dates:	10	1	1□Yes 2【X	No Spe	ecity:			Specify:	hite, etc. white
disa	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	tent's Usual C	ccupation lone during	most of working	7		nd of Busine	ss/Industry
Tal Ma	duic	Elementary/Secondary (0-12)	College (1-4or 5		Depart						dical surano	ce
	To Be Co	17. Father's Name (First, Middle, Last) Joseph Parks			,		18. N	Mother's Name (Maiden	Sumame)	
2 2		19a. Informant's Name/Relationship (T	ype, Print)					umber or Rural				
other tr		Gary C. Wirth 20a. Method of Disposition	/_sc		B304 Place of Dispos			Circle;				or Town, State
any injury or of		1 Burial 2 Cremation 3 :	Removal from State	0	emetery, cren eland	natory or othe	r place)	9/29/			kville	
ınlur	-	21. Signature of Funeral Service Licens		INOT		. Name and A			03			ck Road
ang Subs		1 Veta	Church		Ru	ck Tow	son F	uneral	Home			MD 21204
cian dical niner	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Soly Due to (or as a b. Oropi Due to (or as a c. Due to (or as a d.	t ii ji ya a donayo	uence of):	Oyst	in hay in	R				Vee
iched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregr Other (special				2	23d. Date of Month	delivery Day
d be detached	by	Part II. Other significant conditions co	intributing to death bu	ut not res	ulting in the ur	nderlying caus	e given in F	art I.		bacco u:		e to the cause of d
irector, page 2 should b	Completed								24a. Was autop		24b. Were prior death	
ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othor	Place of Death (
unerald	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day	y	ER/Outpatien 28b. Time of Injury		Injury at Work?	_	e 5 ☐ Resid d. Describe h			pecify)
ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At ho c. (Specif	ome, farm, stre	eet, factory, of	fice	28	f. Location (S City or Tow			Rural Route Num
completely filled in by t	edical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examina	wledge, death ition and/or inv	n occurred at t vestigation, in	he time, dai my opinion.	te and place, an death occurred	d due to the d at the time, d	ause(s) date and	and manner place, and c	as stated. due to the cause(s
complet	Me	29b. Signature and title of certifier				29c. Li	cense num	ber	,		•	onth, Day, Year)
2	/	Som / Star	ompleted cause of de mo , 656)		100	0611	99		sep.	T, 20	12005
		30. Name and address of person who o	ompleted cause of de	eath (Iten	n 23a) (Type, I	Print)						

	05–6298		1,00	State of M	larvlan	d / Den	artmeni	of H	ealth a	nd Mei	ntal Hv	gien e	005	01513	ı
AKG			For Unpend Ite	em 23a,27,28	a-f p	er me	G847	9-29	505 _{th} t	as	intai i iy	Reg. No.	005	3 5 7	
			Registrar 1. Decedent's Name (First, Middle							2	Date of De	ath		3. Time of Death	
-	Physici	an	James Howard							S	Month epteml	oer 1	4, 200!	12:05P	A
	/Medio Examir		4a. Facility Name (If not institutio)		4b. City,	Town, or	Location of				County of Dea		
	Exami	iei	800 block Monro	e Street			Balt:	imor	A				N/A		
W)	Funeral		5. Social Security Number	6. Sex 7. A		ast birthday)		1 Year Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Bir (Month, Da 1n . 3	th v. Year)		hplace (State or Foreiguntry)	m
305	Director		218-96-2540	1 2 M 2 □ F	29	Yrs.	I I I			Jι	in. 3,	197		yľand	
9	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limit	s
	laryla Pho	ត		/A			altimo	re						1∭X Yes 2 □ N	
	1he N	ect	10e. Street and Number	,			10f. Zip					10g. Citiz	zen of What Co	untry?	
	hours after death with the Maryland turel', or itame 23a or 28a-f ahow at Examinar rouch be notified at	Funeral Director	2510 Wilkens A	Venue					21223	2					
	ne 2	era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Deced	ent of Hi			y Yes or No		ted Sta	ncan Indian,	
(O	or iter		1 Never Married 2 Mar	ned 1 Yes 2 2			If Yes, spec			, Puerto Hic	an, etc.)		Black, Whit		
Š	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			TLI Tes 2	K7 140	Зрвспу:				Specify: V	hite	
5-0	72 honetur	Completed		nt's Education est grade completed)		(Give	dent's Usua kind of wor	k done d	luring most	of working		16b. Kir	nd of Business	Industry	
2	hen he	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us		,				0		
2	led w tygie her t		11. Father's Name (First, Middle,	Lacti			Mason	-	18 Mother	r's Name /F	irst, Middle	Maiden		uction	
anc	ntal H	Be	Harry Raymond							·	ice Ve		Sumumey		
Ž	hould d Me mark mark	10	19a. Informant's Name/Relations			19b. Maili	na Address	(Street a					Town, State, a	Zip Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23s or 28s-f ahow any injury or other traumatic avant, the Medical Examinat: wat be notified at ODGE.		Florence Guarn										L 34606		
ē,	Hea tem		20a. Method of Disposition		20b. P	lane of Dies	naine /Alex			Date			cation - City or		_
Ω.	ages ant of nt: if i		Burial 2 Cremation 4 Donation 5 Other (Bay	view Cremat	Crsz	Tnc	9)	-24-2	005	D o 1 s	timore,	MD	
₹	artm ortar inju		21. Signature of Funeral Service		1	ALO 2	2. Name an	d Addres	s of Facility	Ambro	se Fu	nera	1 Home,	Inc.	
ä	Per im per		L * DOWN HOWN	M) WHI	STL.								ıs, MD		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	d the death									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Morphin		oxicat	tion							Onset and Death	
	/Medical		resulting in death)	Due to (or as											
	Examiner		Sequentially list conditions.	b											
	sit ad	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequ	ience of):									
	ecuti and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a consequ	ence of):									
760,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	calE													
587	ficate phys			d											
Вох 68	nding use a	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of de	ivery	
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pro □ Other (spe						Month	Day Year	
0	t the by the	Physician/Med	9 ☐ Unknown	9□ Unknown											_
Division of Vital Records, P.O.	as tha	by P	Part II. Other significant conditi	ons contributing to death	but not resu	ıltıng in the u	inderlying ca	use give	en in Part I.					the cause of death?	
ğ	equire en si ould b	bed									10	Yes 2	No 3∏Pr	obably 4 Nnknow	1
Ö	as be	Completed									24a. Was autor	DSV	prior to	topsy findings available completion of cause of	е
<u>~</u>	The page	Sol										rmed? 2□ No	death?	2 □ No	
/ita	sician: The law cartificate has t irector, page 2 s	Be	25. Was case referred to medica examiner?	Hospital:				Otha			heck only o				
of o	Physic this c	7	1 X es 2 No 27, Manner of Death	1 ☐ Inpati		ER/Outpatie		A Othe Bc. Injury	4 🗆 Nur		5 Resident			nk	
u	ding h. After funer	lon	1 □Natural 5 □ Pendi	77 (Month ()	ay Year)	Fourtd 11:45		Work	:?ີ່ ∕es 2. X IN		. 50001.50		a a	шк	
isi	Attan deat ctor: y the	fica	3 ☐ Suicide 6 ♣ Could	not be							Location (Street and	Number or Ru	ral Route Number,	-
ă	al or after	Certification:	4 Homicide determ	Found u	itc. (<i>Specify</i> I nder	bridge	9			Ba	1timo	m, State) re. I	800 B1	k. Monroe	St
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this cartificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the			ng Physician: To the bes						d place, and	due to the	cause(s)	and manner as		
	ha H in 24 in 8 in 8 in 9 plete	Medical	one)	Examiner: On the basis and manner s		ion and/or in				n occurred					
	Your To I	Σ	29b. Signature and title of certific			/	29c	. License	number			29d. Date	signed (Mont	h, Day, Year)	
	IL ad		• //	1 ms RII	PLE	In	0.0	C.M.	Е			Sept	ember 1	5, 2005	
1	the pink		30. Name and agrees of person	who completed cause of	death (Item	25a) (Type,	Print)	C+		ייו-		M	, ,	1.001	
	,		31. Date filed (Month, Day, Year	7, 10-7	res Sinna	TTT	renn	Str	eet,	Balti	nore,	Mary	rand 2	1201	
	Sta Regista		CED	2 8 2005	LACOR.	1 15	1000								
			<u> </u>	NO LY	-										

				1 - For State Registrar	State of Maryla	nd / Depa			lental Hyg	iene) I~ ^) IE LO
			4	Hegistrar Decedent's Name (First, Middle, Last,		001	inicate of	Dealli	2. Date of Deat	3		3. Time of Death
		Physic /Medi		Miriam Eunice	Aungst				Septemb	er 18,	^{Year} 2005	2330 ^M
		Exami		4a. Facility Name (If not institution, give				r Location of Death		4c. County	of Death	
		Funeval		Upper Chesapeak 5. Social Security Number 6. Secur		nter . last birthday)	Bel A		9 Date of Birth	Har	ford	(2)
		Funeral Director			M 21XIF 88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 11,	^{Year)} 1917	9. Birthplace Country) Mary]	e (State or Foreign and
		death with the Maryland ms 23e or 28a-1 show	_	10a. State 10b. County		ity, Town or Lo	cation					Inside City Limits
	30	ith the Marytar or 28a-1 show	Funeral Director	MD Harfor	d i	Aberdee						1 ☐ Yes 2 ☒ No
	2330	With 1	ığı	1202 Carsinwood	Ct		10f. Zip Code	001	10	og. Citizen of W U.S.A		?
	~	death	nera		12. Was Decedent Ever in L	J.S. 13. V		ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		- American I	ndian,
	5-0036	72 hours after death with the Maryla "natural", or Items 23e or 28e-1 shou offer Examiner cust by contilled at	ğ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba	an, Mexican, Puerto I Specify:	Rican, etc.)	Specify:	k, White, etc. Whit	:e
/	1	filed within 72 hour Hygiene ther then "natural int, Ire Muliel En	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	ent's Usual Occup	ation during most of workir f)	10	6b. Kind of Bu	siness/Indust	ry
	212		mp	Elementary/Secondary (0-12)	College (1-4or 5+) 4+	Nurse	OO NOT use retired	1)		Nursin	a	
		be filed withinal Hygiene.	a)	17. Father's Name (First, Middle, Last)	41	1.0250		18. Mother's Name	(First, Middle, M			
	ylar		To B	B. Burdell Pres	ton			Beulah W	<i>l</i> elsh			
	アル Maryland	77 10 10 10		19a. Informant's Name/Relationship (Ty) Roger Preston (g Address (Street) 9 Churchy	and Number or Rura				de)
		$C = G_1 -$	1 8	20a. Method of Disposition			sition (Name of patory or other place			en, MD Oc. Location - (State
-	7/18/05 altimore,	Pages nent of nt: If i		1XDBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		cemetery, crem cer Cem		9/23/		berdeen		State
-	9/18/05 Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other		21. Signature of Funeral Service License			Name and Address	- '			•	
7	8760, (I)	Physician / Medical Examiner phe prize phe pri	icai Examiner	23a. Pant. Enter the disease, or compinion shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection) Due to (or as a consection) Due to (or as a consection)	quence of):	ral k	g, such as cardiac or	respiratory arres	st,	App	proximate erval Between set and Death
C). Box 6	The faw requires that the death certificate be executed tte has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ○ No 9 □ Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ıl death 3 □I	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day	Year
	r /Irram ecords, P.C	uires that signed k lid be dett	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	derlying cause give	n in Part I.	1	cco use contrib		use of death?
-	= 0	aw requii is been s 2 should	Completed	Demen	1.20				24a. Was an			indings available
<	- A		Com	October	YD(5'				autopsy performe	ed) pri	or to complet ath? Yes 2	tion of cause of
1	\ /ita	iysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?				26. Place of Death	-	_	1.63 2	140
	\$ C	d is	- To	1 ☐ Yes 2 No Ho 27. Man of Death	0	ER/Outpatient	3□ DOA Othe	4 Nursing Hom				
	ر الا	ting After fune	tion	1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at 28 ? ′es 2 □ No	ld. Describe how	injury occurred	d	
	$\mathcal{A}(\mathcal{R})$ Division	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree			If. Location (Stre City or Town,	et and Number State)	or Rural Rou	ite Number,
		Hospita 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Check only one)	cian: To the best of my kno ar: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and place, an inion, death occurred	d due to the cau	se(s) and manr	ner as stated. d due to the o	cause(s)
		To the within To the comple		29b. Signature and title of certifier	and matter states.		29c. License			. Date signed (
1		_		> Hare Sin	u (Cym /	/	Dz	7364	5	eptem	ber 19	,2005
		3		30. Name and address of ptre n who con	npleted cause of death (Item	23a) (Type, P	deen	Mary	land			117.0
		Sta		31. Date filed (Month, Day, Year)	32. Jegistrar's Signa	ture		 	3			
		Registra	ar	SEP 2 1 200	3 Beller	Or Ha	mill is					

			For State Registrar	State of Mai		artment of Health Tificate of Deat		tal Hygie	7110:	31519
			Decedent's Name (First, Middle, Last)				2. [Date of Death		3. Time of Death
п	Physicia		Jerome	Darsen	Allen			Month	Day Ye	i M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location		- L	4c. County of D	
	Examin	Ç.	Holy Cross Hos	pital		Silver Sr	ring		Montgo	Omerv
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)		er 24 Hrs. 8. [Date of Birth Month, Day, Ye	9.	Birthplace (State or Foreign Country)
	Director		579-58-4070 ¹⁸⁴	M 2□F 5	8 Yrs.	Wichters Days 110011	9	/26/46		Wash. DC
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	anyla shov	5								1 ¥Yes 2 □ No
	28a-f	Director	Md. P.G.		rembre	Hills 10f. Zip Code		100	Citizen of Wha	t Country?
	a or			D 1						
	eath	Funerai	3043 Brinkley	ROAG 12. Was Decedent Ev	ver in U.S. 13.1	20748 Was Decedent of Hispanic	Origin? (Specify	Yes or No-	14. Race - A	American Indian,
	fter d	표	1 ☐ Never Married ★ Married	Armed Forces? 1 ☐ Yes 2 📆 No	, !	f Yes, specify Cuban, Mexi-	can, Puerto Rica	in, etc.)		White, etc.
93	hours after death with the Maryland burst; or Itams 23a or 28a-1 show at Examinat must be nutified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Spec	ify:		Specify:]	Black
Ö	d within 72 hours after death with the Marylan Jiene. I then "naturel", or Itams 23a or 28a-1 show The Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade			lent's Usual Occupation kind of work done during m	inst of working	161	. Kind of Busin	ess/Industry
21	within 7 ene. than "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired)	oot or working			
21	filed with Hygiene. Ather than	Co	12th		E1	ectrician			Priv	vate
Maryland 21215-0036	S 2 2 5	Be	17. Father's Name (First, Middle, Last)	h. 1 -			ther's Name (Fil			
<u>Y</u> a	71 5 5 0	၉	Not Availa				ladys			
Jar			19a. Informant's Name/Relationship (Type			ng Address (Street and Nur.				
	l ar		Jean L. Allen/W 20a. Method of Disposition	ııe	20b. Place of Dispo	Brinkley sition (Name of	Rd. Te			Md. 20748 y or Town, State
وّ	nges in the		1 Burial 2 □ Cremation 3 □R	emoval from State	cemetery, crer	natory or other place)	9/16			
Baltimore,	nit. Pages Partment of h ortant: If Ite		 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign are of Funeral Service License 	20		Mem. Park Name and Address of Fa		/03 L	andove	er, Md.
Ba	Departmi Departmi Importar any Injur		10 me (8 10)	Munic	/	The House	of Wil	liams	Fun. S	Svc.
	-		23a Part1. Enter the disease, or compli			814- Upshu er the mode of dying, such				Approximate
			shock, or heart failure. List only on Immediate Cause (Final							Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Sepsis	consequence of):					
	Examiner			Fungem						
		ē	Sequentially list conditions, if any, leading to immediate		consequence of):					
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Clesase of Injury) that initiated events							
0	s be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760,	he hy	dlcai		l						
9	eath certific attending p I for use as 1		IF FEMALE:	2- K	f ========					V
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown	ime or death 5	Other (specify)				
0	that the de led by the a detached		Part II. Other significant conditions con	tributing to death but	t not resulting in the u	nderlying cause given in Pa	rt I.	23e. Did tobac	co use contribu	te to the cause of death?
Records,	uires sign	d by						1 🗆 Yes	2 □ No 3 □	Probably Minknown
S	w requ been should	ete						24a. Was an	24b. Wer	e autopsy findings available
Re	The lav	Completed						autopsy performed	t? deat	
Vital		e C	25. Was case referred to medical			26 PI	ace of Death (C)	1 ☐ Yes 2XX	NO I	Yes 2□ No
>	Physician: this certific ral director,	0 B	evaminer?	lospital:	it 2 ER/Outpatier	Other	Nursing Home		e 6 Other ((Specify)
10		n: T	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o		28d.	Describe how	njury occurred	
ior	uttendin death. ctor: Aft y the fun	atio	1 ▼Natural 5 □ Pending 2 □ Accident investigation	(Menan, day		M 1 ☐ Yes 2	□No			
Division	l or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, farm, str (Specify)	eet, factory, office		Location (Stree City or Town, S		or Rural Route Number,
	ital o rs aft ral Di	Cer								
	Hosp 4 hou Fune ely fil	ca	(Check only 2 Medical Exami	ner: On the basis of	examination and/or in	n occurred at the time, date vestigation, in my opinion, o				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	one) 29b. Signature and title of certifier	and manner stat	ea.	29c. License numb	91	294	Date signed /A	Month, Day, Year)
	Nait No I		250. Signature and title of Certifier					200.	2/11/	
•	3		- Graj	mD	ash /lsa=- aa a	D0050	0003		1/1/0	1
			30. Name and address of person who co				n		- 3	
	. Sta	ite	Kanwaljit K. I 31. Date filed (Month, Day, Year)	32 Registra	r's Signature	orest Gler	LKa. S	.s., M	id.	
	Regist		SEP 1 4 20		15. Pg	sign)				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland
Department of Harth and Mental Hygiene
Important: If them 27 is marked other than "naturel", or Itams 23a or 28a-1 ehow
a Signature

of Vital Records, P.O. Box 6876

26 Camil

			Please	Type or Prin					_				
			1- State Amond Tto		-	•			wieniai ny	Reg. N	7 0 0 mg	31	520
		25	1. Decedent's Name (First, Middle, Las	<u>m 26 per</u>	nosp.,G	040,107	297030		2. Date of De	aath		3. Time	of Death
	Physicia /Medic	_	Evelyn Eliza	beth Bull					Septem	ber	10 2005	5:5	SO AM
	Examin		4a. Facility Name (If not institution, give	street and number)	D. 11.		2.11	Location of Deatl	1 Cit	4c.	County of Deat	th	
	2000		5. Social Security Number 6. Se	7. Ag	e (In yrs. last bi		DOUT er 1 Year	If Under 24 Hrs.	8. Date of bi	rth Vanal	9. Birt	thplace (State	e or Foreign
	Funeral Director			□ M 3/□ F	95	Yrs. Months	Days	Hours Min.	Jun_24			ountry) ryland	
pue	>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside	City Limits
Marv	-1 eho	tor	Maryland Balti	more				Sparks	5			1 🗆 Y	es 2√No
th the	or 28a errotti	lrec	10e. Street and Number			10f. Z	ip Code			10g. Citi	izen of What Co	ountry?	
ath 💌	23a ustb	Funeral Director	2125 Stringtown H			140.1112		2115			USA 14. Race - Ame	vican Indian	
er de	ltams rier	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		13. Was Dec	ecify Cubar	spanic Origin? (S n, Mexican, Puerl	to Rican, etc.)	0-	Black, Whit		
should be filed within 72 hours after death with the Marviand	el', or	þ	3X Widowed 4 □ Divorced	1 ☐ Yes 2√ If Yes, Give Year or Dates:		1 🗆 Yes	2 No	Specify:			Specify:	white	:
2-0-10-10-10-10-10-10-10-10-10-10-10-10-1	natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>	168	Decedent's Us (Give kind of w	rork done di	uring most of wor	rking	16b. Ki	ind of Business	/Industry	
Mithight I	than than	ldu	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. DO NOT Home	use retirea) emakej				Own Ho	ome	
A Land	Hygie other ent, II	a	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)		
yland guld be file	Aental rked tlc ev	To B	John George Nay	ylor				Franc	es Bull				
Mary	and Is ma	ľ	19a. Informant's Name/Relationship (7		19	b. Mailing Addres		_				Zip Code)	
6, 2	Health		Vernon M. Bull, s	son	20b, Place	2125 St. of Disposition (N	ame of		Date		Cation City or	Town, State	
	t: If Its		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			ery, crematory or Zion UM			13/2005	τ	Jpperco	, MD	
Saltimor	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itams 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be rightlind at once.		21. Signature of Femeral Service Licen		723		and Address		Eline F	unera	al Home		
Ď à	Depa Impo eny iu		Hower	Wel	ine			Main St			, MD 210	Harris Allen St.	
			23a. Part1. Inter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	the death. Do	0			c or respiratory a	arrest,		Approxim Interval E Onset an	Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 110	a consequence		1'0 m	5					
	xaminer		1		a consequence	oij.							
	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							
J, executed	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):							
5	ettending physician and for use as the burial-transit	-		d									
Geath certificate be	ng phy as the	Physician/Medica	15.50.015										
XOU IN	ttendir or use	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal deat						23d. Date of del Month	livery Day	Year
٠ غ	the e	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time or death	5 Other (specity)						
J = ==================================	signed by the e	by Pr	Part II. Other significant conditions of	ontributing to death b	out not resulting	in the underlying	cause give	n i n P art I.	23e. Did	tobacco u	use contribute to		
COLDS, P	been sig								1 🗆	Yes 2	□No 3□Pi	robably 4	Unknown
a a	2 s b	Completed							24a. Wa:		24b. Were au prior to death?	completion of	gs available if cause of
	pa		OF Management of medical					ac Pi of Do	1 ☐ Yes ath (Check only	2 12 No	1 ☐ Yes	2 2 No	
OT VITAL	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/C	Outpatient 3 🗆 🗈	OCA Othe	7. 4 Nursing h			6 □Other (Spe	ecify)	
	fter th	no.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	lry Year) 28b.	Time of Injury	28c. Injury Work	at ?	28d. Describe				
DIVISION	tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be		iun. At homo	M farm, street, facto		′es 2 □No	28f Location	(Street an	d Number or R	ural Route N	um ber
= 2	after after d in by	Certificati	4 Homicide determined	building, e	tc. (Specify)	ianii, siieet, iacii	ory, ornos		City or To	wπ, State)		
Hoenies H	within 24 hours after death. To the Funeral Directors After this sertific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis of	of my knowledg	ge, death occurre	d at the tim	e, date and place	e, and due to the	cause(s)	and manner as	s stated.	A(S)
4	hin 24 the F	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		9c. License				te signed (Mont		
F	2 1 × 0		290. Signature and time of certains	MA M	D		Δ	000		Se	sten ber	10 2	005
	15		3p. Name and address of person who	completed cause of	death (Item 23a) (Type, Print)	,	£ D	altim		1	100	
	Dr		Amy S. Kimball	MD	Sinai	Huspi	121	01 B	altim	01.	e		
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Regist	rar's Signature	Hospi	٠,						
100	F 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	\mathbb{S}_{1}, Ψ	257 1 9	LUUJ! C	West St	12 10 14	<u></u>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1624 PM SEPTEMBER ALAN BROOKS 13, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 26,1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 11X M 2 □ F 217-58-0660 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Glen Burnie Director Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7965 Shetlands Dell 21061 USA Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married white 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvements Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl S. Brooks Dorothy L. Hardy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7965 Shetlands Dell, Glen Burnie, MD 21061 Linda L. Hogle, sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremations 09/15/2005 Hampstead, MD 21. Signature of Funeral Service Licensee 2 M00723 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days disease or condition resulting in death) respirato y Due to (or as a consequence of); metastionic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20'No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. Ducton D0059736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOZTITWEST HOSPI TAL DEBORAH 32. Reg Krar's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "naturel", or Items 23e or 28e-1 show eny injury or other treumatic event, the Medical Evantment.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

Hospital or Attending Physicien: The law requires that the death certificate be executed

this

After 1

after death

within 24 hours a To the Funerel C

filled in by the funeral

Division of Vital Records, P.O. Box 68760,

SEP 1 5 2005

	ľ	1- State of Maryland / Department	artment of Health and Mertificate of Death	ental Hygiene	005 31522
Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
/Medic	al	Yau Broome 4a. Facility Name (If not institution, give street and number)	4b. Cify, Town, or Location of Death		8 2005 18:44 PM
Examin	er	University of Maryland Medical Center	Baltimore	40. (N/A
Funeral		Social Security Number	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Director		215-74-2830	P	lay 27, 196	8 Maryland
yland		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
th the Marylan or 28a-f show	ctor	Maryland St. Mary's Abell			1 ☐ Yes 2 🛣 No
	Directo	10e. Street and Number	10f. Zip Code		en of What Country?
death ms 23	Funeral	21.595 Abell Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. 1	Was Decedent of Hispanic Origin? (Spec	try Yes or No- 1	4. Race - American Indian,
after or ite		1 Never Married 2 Married 1 ☐ Yes 2 No	f Yes, specify Cuban, Mexican, Puerto R 1 □ Yes 2⊠ No — Specify:		Black, White, etc.
72 hours after death w natural, or items 23s	d by	3 Widowed 4 Divorced Year or Dates:			Specify: Black
n nat	plete	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	g 160. Kin	d of Business/Industry
ad with	Completed	9 Labor	rer	Fen	cing
be file	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden S	Sumame)
ges 1 and 2 should be filled within 72 hour of health and Mental Hygiene. If item 27 is marked other than "natural or other traumatic event, the Madical E.	ပ္	Joseph Aloysius Broome, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Dulca Ann ng Address (Street and Number or Rural	-	Town, State, Zin Code)
nd 2 salth ar 27 is ir trau			Abell Road, Abell, Mar		, , , , , , , , , , , , , , , , , , ,
es 1 and 3 of Health If item 27 or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dispo	sition (Name of Da natory or other place) Septem		cation - City or Town, State
Pag tment tant: h jury o		'4 □Donation 5 □ Other (Specify) Charles Mem	orial Gardens 23, 2		rdtown, Maryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Mai	d. Name and Address of Facility Ctingley-Gardiner Funer	al Home, P.A.	
300-05		23a, Part1, Enter the disease, or complications that caus at the death. Do not ent	 Box 270, Leonardtown er the mode of dying, such as cardiac or 		Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Large Left Ple	ural Effusion		Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):			
Examiner	_	Sequentially list conditions. But to lor as a consequence of the conditions of the			
rted Insit	Examiner	Cause (Disease or injury			
exect an and rial-tra		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
cate be executed only sician and the burial-transit	dical	d			
death certifica attending ph	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		200	3d. Date of delivery
ires that the death cer signed by the attendin d be detached for use	hysician/Med	1 Live birth 2 Fetal death 3 in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
by the cachec	hys	9 ☐ Unknown			
res tha	by P	Part II. Other significant conditions contributing to death but not resulting in the use Acute Renal Failure	nderlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death? No 3 Probably 4 Unknown
w requii	eted	MUTE REMAI MITORE			
he law s has l	ompleted			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
vician: The lar certificate has rector, page 2	CO	25. Was case referred to medical	26. Place of Death	1 Yes 2 No (Check only one)	1 Yes 2 No
Physici Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Hom	e 5 Residence 6	Other (Specify)
ing Pl		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	8d. Describe how injury	occurred
Vitend death ctor: ,	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, str	M 1 Tyes 2 No	Bf. Location (Street and	Number or Rural Route Number.
al or A	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and conflicted in by the funeral director, page 2 should be detached for use as the burial-transit.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of t			
To th Within To th compl	Me	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
CHE		PRACOMD	16686	Septen	aber 18,2005
		30. Name and address of person who completed cause of death (Item 23a) (Type, Penali Notice wala UMMC Dept. of	Internal Medicin	e Baltimo	ere street pre, MD 21201
Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2005	hode		

DHMH 17 Rev 1/2001

AEM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. # 05-06353 State of Maryland / Department of Health and Mental Hygiene Lewis Edward Blackistone Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician September 17, 2005 Lewis Edward Blackistone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Point Lookout State Park Scotland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Months Hours **Funeral** 1 ₹ M 2 □ F 29 Maryland Oct 25, 1975 217-86-3601 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a. State r than "natural", or itams 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director Hollywood Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20636 44303 Clarks Landing Road Funeral 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give 72 hours after 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Unemployed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked Sandra Lee Phelps Thomas Dewey Blackistone, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) : If itam 27 in or other tre 44303 Clarks Lndg. Road, Hollywood, Maryland Sandra Lee Bolnke/Mother 20c. Location - City or Town, State Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
important: If iter
any injury or oth 1

Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Gardens Sep 22, 2005 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, p.A. 21. Sign re of Funeraf Service Licensee P. C. Box 270, Leonardtown, Maryland 20650 23a. Part I. Enter the dise ise, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) 1 Rowerry **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician end for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box 23d. Date of defivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. the 9 Unknown s been signed by should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 death2 1 Yes 2 No 1 Yes 2 No of Vital 26. Place of Death (Check only one) Medical Certification; To Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene 1 Yes 2 No 28d. Describe how injury occurred tuneral 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 27. Manner of Death After Division 5 Pending 1 Naturaf 1 ☐ Yes 2 🖢 No SWIJEU D NOWNED tours efter death.

neral Diractor: Af tario 9-17-08 7:00A M investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide POWTLOOKOUT STPKSTMDAY'S BODY OF WATER within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 18, 2005 OCME WW) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 D. KORELL 31. Date filed (Mon SEP egistrar's Signature State 2005 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

CPM 05-06156 Unpend item#23a, 27, 28a-f, perME, G848, 10/12/05 TI
State of Maryland / Department of Health and Mental Hygiene Isaiah Brown 1 - State Registrer Certificate of Death Reg. No. 0.052. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day September 08, 2005 **Physician** BROWN LSAIAH 15:08 CHARLES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Apr. 7. Z.O. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 5 mth Yrs. 220-71-7002 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28e-f show worle 1 Yes 2 No MD. FREDERICR FREDERICK **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6300 ITRRACE 21701 U-S.A. the Madical Examiner must be IVERSON 238 filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Iteme 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. NA Elementary/Secondary (0-12) College (1-4or 5+) NIA AIN permit. Pages 1 and 2 should be filet. Department of Heelith and Mental Hyg. Important: If item 27 is marked other any injury or other treum-**-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DENISE HALL RALPH BROWN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6300 INTERSON TOPP. N. FREDERICK MO RALPH FAMILE BROWN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESTITATION MOM. GAR. SOPT. 13,2005 FRODER VCK, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servin Dicensee FUNDRAL Home 2 Name and Address of Facility FUDDINUM IND 21701 Key Q. JC ATLUGG Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or part failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Hyperthermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physiclen and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) ed by the deteched Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 165 autopsy performed? Yes 2□ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ⚠ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ this 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death Date of Injury Page Time of (Month, Day Year) 28d Describe how injury occurred **Exposed to**high environmental temperature Certification; 1 □Natural 2 X Accident 5 Pending investigation 2:34 P 9/8/05 1 ☐ Yes 2 XNo in car 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6300 Iverson 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Terrace North Frederick, Car 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier O.C.M.E. September 09, 2005

State Registrar O. Name and address of person

23 2005

10

death (Item 23a) (Type, Print) (1), 111 Penn Street, Baltimore, Maryland 21201

			. For	State of Maryla					Mental I		000 =	
			1 - State Registrar		Ce	ertifica	ate of l	Death			va2 U U 5	
	Physicia	an	Decedent's Name (First, Middle, La						2. Date of Month		Day Year	3. Time of Death 5 //: 62 A M
	/Medic	al	4a. Facility Name (If not institution, giv		7	4h Ci	ty Town or	Location of Deat	09 h		2 200. 4c. County of Dea	
	Examin	er	Montgomery Gene	-			Uney.	MD				emery County
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yi	rs. last birthda		der 1 Year	If Under 24 Hrs Hours Min.	8. Date of	Birth , Day, Yea	9. Bi	rthplace (State or Foreign
	Director		577-58-8095	M 2□F	60 Yrs.				April	19,	1945 Wa	shington,D.C
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or I	Location						10d. Inside City Limits
	Mary L-f sho	tor	Maryland Prince (Georges	Hyatts	ville	е					1 Yes 2 No
	th the	Director	10e. Street and Number			10f. 2	Zip Code			10g. (Citizen of What C	Country?
	ath w		1006 Ray Rd.	10 W D - 1 - 1 - 1	11.5			sville	Specific Verse		ited Sta	
_	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 Tyes 2 No	10.5.			ispanic Origin? (S In, Mexican, Puer	to Rican, etc.)	Black, Wh	ite, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hysiene. Hybrettan natural, or Items 23a or 28a-f show ant, the Maclical Examinar must be modified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 ₾ №	Specify:			Specify: B	1ack
ည	72 ho	Completed	15. Decedent's E (Specify only highest gra		16a. Dec	edent's U	sual Occup work done	ation during most of wo	rking	16b.	Kind of Busines	s/industry
121	within ane. than	lduu	Elementary/Secondary (0-12)	College (1-4or 5+)			ing Si	" uperviso	r	Fe	ederal G	overnment
2	filed Hygie other ent, III	Be Co	17. Father's Name (First, Middle, Last)	1			18. Mother's Na	me (First, Mic	ddle, Maid	len Sumame)	
<u>lan</u>	uld be Aental rked tic ev	To B	Gettys Bailey					Sylvia	Posey			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be indiffed at any injury or other traumatic event, the Madical Examinat must be indiffed at any injury or other traumatic event, the Madical Examinat must be indiffed at		19a. Informant's Name/Relationship (-		and Number or Ri				Zip Code)
	1 and Health Im 27		Georgia Bailey / 20a. Method of Disposition					Hyaatsvi	Lle, M		20783 Location - City o	r Town. State
5	Pages nent of h ant: If Ite		1 XBurial 2 ☐ Cremation 3 ☐	THemoval from State	o. Place of Dis cemetery, cr				16 20			
Baltimore,	artme orten injury		'4 ☐Donation 5 ☐ Other (Special Service Section 21. Signature of Funeral Service Section 21.	1220	aryland			Sept S S Pope			neltenha	
B	Depa Impo any is		POTTE CIAN	×1 MO1085				boro Pil				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	eath. Do not e	nter the m	node of dyin	g, such as cardia	c or respirato	ry arrest,		Approximate Interval Between Onset and Death
, 1	Physician		Immediate Cause (Final disease or condition	a Urose	4							Unknown
h	/Medical Examiner		resulting in death)	Due to (or as a cons		-)		41				113 11
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	ic En	cep	nano	rathy_		·		Unknown
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Circh	10515							Unknown
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a cons	,	D.	. 0					Unknown
Φ.	cate b physic the b	dlcal	•	o. End	Stage	New	U Du	rease				
9 X	Attending Physician: The law requires that the death certilica rideath. If death. ector: After this certilicate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-							23d. Date of de	əlivəry
.О. Вох	death death	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		B ∐Ectopio □ Other	pregnancy (specify)				Month	Day Year
О. О.	at the by the	hys	9 Unknown	9□ Unknown								
s S	res th signed be de		Part II. Dther significant conditions	contributing to death but not	resulting in the	underlyin	g cause giv	en in Part I.			2 □ No 3 □ F	to the cause of death? Probably 4 Unknown
Ö	w requir been si should	Completed								Was an		autopsy findings available
Rec	ne law has l ge 2 s	mpi							a p	utopsy enformed	prior to death?	completion of cause of
ī	an: Ti liticate or, pa	a)	25. Was case referred to medical					26. Place of De	ath (Check o		No 1 □ Ye	s 2 No
<u> </u>	Physicia this cert al direct	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2	☐ ER/Outpati	ent 3	DOA Oth	or			6 ☐Other (Sp.	ecify)
0	ng Ph fter th meral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	/	28c. Injur Wor		28d. Descr	ibe how in	jury occurred	
Division of Vital Records,	tendl Jeath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	De Blace of Injuny A	t home form	M street fee		Yes 2 □No	28f Locatio	on (Street	and Number or F	Rural Route Number,
$\frac{1}{2}$	I or Attendate death Director:	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	stieet, iac	lory, office			Town, Sta		,
	To the Hospital or Attending Physician: The lav Within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2		29a. Certifier 1 Certifying P	hysician: To the best of my l	knowledge, de	ath occurr	ed at the tim	ne, date and place	e, and due to	the cause	(s) and manner a	as stated.
	To the Ho within 24 To the Fu completel	edical	one)	miner: On the basis of exam and manner stated.	ination and/or				urred at the ti			
	With To	Σ	29b. Signature and title of certifier	i i			29c. Licens				Date signed (Mor	
Λ	(In		Cohit Kynt boku	ing	tem 22a) (T	a Dries	106	2653			1/12/05	>
1	(10)		30. Name and address of person who Robert Ryan Ho	4			General	Hospital,	Olnen.	M.D.		
	Sta		31. Date filed (Month, Day, Year) SEP 1 5 200	3 Registrar's Si	gnature		_	1	/)			
	Registi	d-172	1 SEP 15 707	17 17/13	He Ha	F	1					

		•	For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artmei <i>tifica</i>	nt of He te of D	ealth a Death	and M	ental Hy	giene Reg. No.	, 0 3		1020
			Decedent's Name (First, Middle, L.	ast)							2. Date of De	aath Day		'ear	3. Time of Death
Phys			Theodore	Freeman	Byers,	Jr.					Septer				0020 ^M
Exan	dica nine		4a. Facility Name (If not institution, gi			-	4b. City	, Town, or	Location of	of Death		4c.	County of	Death	
ZAGI			Fort Washi	ngton Ho	ospital			Ft	. Was	hing	ton		Pri	nce	George's
Funer	al			Sex	7. Age (In yrs.		If Unde	r 1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9	Birthpla Count	ace (State or Foreign ry)
Directo			579-98-0193	1 XM 2□F	41	Yrs.					March (6, 19	164		sh., DC
pu »		-	Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	cation							10	d. Inside City Limits
anyla shov		۱				,, , , , , , , , , , , , , , , , , , , ,									1 X Yes 2 □ No
he M	1	Director	Maryland Prince 10e. Street and Number	George'	S			emple	e Hil	ls		10g Citi:	zen of Wh	at Count	rv?
with t	i	בֿ		D 1			101. 2	p 0000	20	748	ĺ				tates
eath s		Funeral	3908 Brinkl		edent Ever in U	I.S. 13. 1	Was Deci	edent of His			cify Yes or No	0-	14. Race -		
ler de item	١.	5	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Fo	orces?	,	f Yes, sp	ecify Cubar	n, Mexican	, Puerto F	ecify Yes or No Rican, etc.)		Black,	White, e	tc.
irs aff		ò	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve T		1 🗌 Yes	2 X No	Specify:				Specify:	В1	ack
2 hou			15. Decedent's I			16a. Dece	dent's Us	ual Occupa	ition	a at wardsie		16b. Ki	nd of Busi	ness/Ind	ustry
nin 72 nin Media	1	ble!	(Specify only highest g	rade completed) College (1-4or 5+)	life.	DO NOT	ork aone a use retired)	iuring mosi)	t or workir	ng				
d with		Completed	Elomontary, coconically (o 12)	4			Ma	rine	Bio1	ogis	t		Gov	ernm	ent
other to		Be C	17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)	+	
Menta Menta riked		0	Theodore F	reeman I	Byers,	Sr.					Da1	e Jan	e Ba	llar	đ
portition (e.g., Midal yilding A.I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. In Medical Exponent must be rollified at	1		19a. Informant's Name/Relationship				•				i Route Numb				
and 2 and 2 alth n 27 is			Michelle Bye	rs / Wii					ey Rd		emple I				748
Tite a			20a. Method of Disposition 1 Durial 2 Cremation 3	□ Removal from	i i	Place of Dispo ce <i>metery, crei</i>	sition (Na natory or	ame of other place	e)	D	ate	20c. Lo	cation - C	ity or Tov	vn, State
Definition Pages Department of Mportant: If it any injury or or	.	1	4 □Donation 5 □ Other (Spec	eify)	Λ Ha	rmony 1	1emo1	ial I	Park	9/13	/2005		Land	over	, MD
mit. partr port. y inj	ouce		21. Signature of Furieral Service Lice	ensee	#	22		ind Addres			ewart]				
0 89E	9		John .	Musa	W, W						, N.E.		1., D	C 20	
	ı		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final	y one cause on e	caused the dea each line. orly di								ivor		Approximate Interval Between Onset and Death 3 months
Physicia /Medic	_		Immediate Cause (Final disease or condition resulting in death)	_ a	(or as a consec		Tate	eu Sina	all C	ell (cancer	01 1	TVEL		J IIIOITETIS
Examin			1	Due to	(or as a consec	quence on.									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a consec	quence of):						-		-	
uted I Insit	-	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
/, exect n and ial-tra		EX	resulting in death) Last	Due to	(or as a consec	quence of):									
e be e /siciar e burit	1	dical		€d											
ificat g phy as the	:														
The COLUS, F.C. BOX 60/00, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		Testonic	pregnancy				2	23d. Date		
death		Cla	in the past 12 months? 1 □ Yes 2 □ No	4 Pregr	nant at time of		Other (Month	n I	Day Year
tithe by th	1.	hys	9 Unknown	9 Unkn	iown										
w requires that been signed to should be detailed.		by P	Part II. Other significant conditions	contributing to d	leath but not re	sulting in the u	nderlying	cause give	n in Part I.						e cause of death?
taw requires tax been signed as been signed as the signed											1 🗆	Yes 2[_No 3	☐ Proba	ably 4 XUnknown
aw re s bec		plet									24a. Was		24b. We	ere autop	sy findings available
The tree has age age		ompleted									perfe	ormed?	dea	ath?	2 No
		ပ	25. Was case referred to medical						26. Place	of Death	(Check only				
VISION OF VITA Attending Physician: or death. ector: After this certific by the funeral director,		0 8	examiner? 1 ☐ Yes 2 🙀 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 E	Othe	9r: 4 □ Nu	rsing Hor	me 5 Res	idence 6	3 □Other	(Specify)
g Phya gerthis		i i	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o		28c. Injury Work	at	2	28d. Describe	how injury	y occurred	i	
ath. r: Aff		atio	1 ♠Natural 5 ☐ Pending 2 ☐ Accident investigati	on	, , , , , , ,		М		Yes 2	No					
or Attending after death. Director: Afte in by the fune		tite	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 200. Flace	e of Injury - At I	nome, larm, str	eet, lacto	ry, office		2	28f. Location (City or To	Street and wn, State	d Number)	or Rural	Route Number,
tai or rs aft		Certification:													
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		edical	29a. Certifier 1 X Certifying F (Check only one) 2 Medical Ext	Physicien: To the aminer: On the b	e best of my kn pasis of examin nner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the time on, in my op	ne, date an pinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s) date and	and mann place, an	ner as sta d due to	ated. the cause(s)
thin the complete	.	Med	29b. Signature and title of certifier	und man			2	9c. License	number			29d. Dat	e signed (Month, L	Day, Year)
Vitit Con			Po	2-					D433	46		91	113/	25	
		ŀ	30. Name and address of person wh	o completed acti	sa of death /lto	m 23a) /Tuna	Print)					/			
10/					8926 Wo			1. #20	ი1. ი	lint	on. MD	207	35		
	Stat	- I	Rita Gupta, 31. Date liled (Month, Day, Year)		Registrar's Sign	ature		11 6	019	· 	CIL CIL	201	J J		
Reg		*	SFP 1 5 200		-	la									

	•		= For AMFND#22 per FH State Registrar 9/13/05 AACO H	State of Marylan	id / Depa <i>Cei</i>	artment of H	lealth and Death	Mental Hy	giene (105	31527
	Physicia		1. Decedent's Name (First, Middle, Last, Betty Lou Clement					2. Date of De Month Septem	Day	Year 2005	3. Time of Death - 12 32 PM
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of De			unty of Deat	
	Examin	er	Anne Arundel Medic			Annapol:			Anne	Arun	del
	Funoval	7	5 Social Security Number 6, Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H		rth	9. Birt	hplace (State or Foreign
	Funeral Director		505-42-9434	M 2 XF 68	Yrs.	Months Days	Hours M	in. 06/22/	71937		raska
	D		Usual Residence of Decedent								404 Inside City Limite
	trylen thow	_	10a. State 10b. County		ty, Town or Lo	cation					10d. Inside City Limits 11 Yes 2 □ No
	Ba-f s	cto	Maryland Anne Arun	ndel Cro	ofton	T			40. 02		
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen USA	or what Co	ountry :
	s 23s		2340 Westport Lane	12. Was Decedent Ever in U	C 12	21114	licoanio Origin?	(Specify Ves or N		Race - Ame	nican Indian,
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show olded Ext. direct must be notified at	Funerai	11. Marital Status 1 Never Married 2 Married	Amed Forces? 1 X Yes 2 □ No		Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)		Black, White	
21215-0036	urs aff	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates: 156-	-157	1 ☐ Yes 2 🛣 No	Specify:		Sp	ecity: Wh	ite
Ö	2 hou	ted	15. Decedent's Edu	ication	16a. Dece	dent's Usual Occup	ation	working	16b. Kind	of Business/	Industry
215	C 2 3	ompieted	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired	d)	*OKNING	1, 1,	-	
2	filed within Hygiene other then rent, I're M	Con		1	Physi	lcians As			Medio		
nd	be filed stal Hygi od other event, II	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle		name)	
yla		은	Walter John Bartle		1			et A. Sno			7.0.41
Maryland	2 sho		19a. Informant's Name/Relationship (7)			ng Address (Street Westpor					zip Code)
45	s 1 and 2 should the Health and Meritem 27 is marke other treumatic		Walter Clements/ S			osition (Name of	t halle	Date			Town, State
Baltimore,	if ite		1 ☐ Burial 2 X Cremation 3 ☐ I	Removal from State	cemetery, crei	matory or other plac					
ţi	t. Partmer rtent rient		4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens		ntt Cre	ematory 2. Name and Addre		/13/2005			
Ba	permit. Pages 1 Department of H Importent: If ite any injury or otl		21. Signature of Autoracounted Endone	h		1111	12	6000 Annowie, MD	apolis	Road	
			23a. Part1. Enter the disease, or comp	lications that caused the dea	th. Do not en	ter the mode of dyin					Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final	aSepsils							Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consec	quence of):						
B	Examiner		O	LEG CELLI	LITIS						
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						
	nd transi	Examiner	cause. Enter Underlying Cause Unsease or injury that initiated events	с.							
00	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consec	quence or);						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical		d							
9 X	ding	/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancy				230	I. Date of del	livery
Box	eath certific attending pl	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other (specify)	у			Month	Day Year
O.	that the di ed by the detached	iysi	1 Yes 2 No	9□ Unknown							
σ.	res that signed b	by Pł	Part II. Other significant conditions co	ontributing to death but not re-	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
rds	quire on sig uld b		OBES174					1]Yes 2□N	lo 3∏Pr	robably 4 🗷 Unknown
Records,	aw requir s been si 2 should	Completed						24a. Wa	s an 2	4b. Were at	utopsy findings available completion of cause of
	0 = 0	mo						per 1 ☐ Yes	formed?	death? 1 ☐ Yes	
Vital		BeC	25. Was case referred to medical				26. Place of I	Death (Check only	one)		
f V	S S P	70 6	examiner? 1 ☐ Yes 2 ☑No		ER/Outpatie	nt 3□ DOA Ott	ner: 4□ Nursin	g Home 5 Res			cify)
n of	ding Phy h. After thi funeral		27. Manner of Death 1 S Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe	how injury o	ccurred	
Sio	r Attending er death. rector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No	29f Location	(Stront and A	lumbor or P	ural Route Number,
Division	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	reet, ractory, onice		City or To	own, State)	<i>2771207</i> 07 7 11	byas riodio rvambor,
	spitel ours a nerel filled		29a. Certifier Certifying Ph	ysicien: To the best of my kn	owledge, deal	th occurred at the ti	me, date and pl	ace, and due to the	e cause(s) an	d manner a	s stated.
	24 h	edicai	(Check only 2 Medical Exemone)	iner: On the basis of examin and manner stated.	ation and/or in	nvestigation, in my o	opinion, death o	ccurred at the time	, date and pla	ace, and due	e to the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. Licens					th, Day, Year)
			1 About			Doc	56658		Septer	nber.	12, 2005
			30. Name and address of person who	4.4			0		(-		21401
			TITUS ABRA			MEDICAL	PARKU	AY, AM	apolis,	md	21401
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Segistrar's Sign	ature						
	riegist	Tai		12000	AS B						

Physician (Middical Examiner) 14. Featily Name of Proof estations of your arrest and number) 14. Featily Name of Proof estations of your arrest and number) 14. Featily Name of Proof estations of your arrest and number) 15. Social Security Number 16. Sex	1- S	For State Registrar			iviai ytai				Death		cina		2 0 S.N.S.	05	31!	52
Section Sect														₹85E	3. Time o	
27070 Sand Trap Court 2606000000000000000000000000000000000	Ro				ner)	Clint		Town or	Location o		sepi	rembe			9:00	A
Social Security Numbers Secu			-		,,,					Douin					0	
216-60-3644 18, 12 19, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10			6. Se	x 7	. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		B. Date	of Birth	1	9. Birth	place (State	or For
Too. State 10b. County 10c. City, Town or Location 10c. Town or Location 10c. Salisbury 10c. Special and Number 10c. Special and Number	216	5-60-3644	10	M 2□F		49 Yrs.	Months	Days	Hours	Min.		15,	1956			
Maryland Wicomico Salisbury 10 Zep Code 109_Clizzen of What Country 100 200_Clizzen and What Country 100					10c. Cit	v. Town or Lo	cation								10d. Inside C	ity I ir
Elementary/Secondary (0-12) College (1-4or 5+) Doctor 1.8 Mother's Name (First, Microtine, Masican Summany)		10.00		_											1 ☐ Yes	
Elementary/Secondary (0-12) College (1-4or 5+) Doctor 1.8 Mother's Name (First, Microtine, Masican Summany)	10e. S	4	COMITCO		Das	LIBBULY	_	Code				10	a. Citizen of	What Cou	ntry?	
Elementary/Secondary (C-12) College (1-tor S+) Doctor Oncologist	27	7070 Sand I	rap Co	ourt											•	
Elementary/Secondary (0-12) Collage (1-for 5-f) Doctor 12 Mother's Name (First, Middle, Last) Doctor 15 Mother's Name (First, Middle, Last) William Louis Clinton Joan Dorothy Fix William Louis Clinton Joan Dorothy Fix Susan Silveria Clinton William Louis Clinton Joan Dorothy Fix Susan Silveria Clinton William Louis Clinton Joan Dorothy Fix Susan Silveria Clinton Wife 27070 Sand Trap Court Salisburry Maryland 200 Method of Deposition Susan Silveria Clinton Wife 27070 Sand Trap Court Salisburry Maryland 200 Method of Deposition Susan Silveria Clinton Wife 27070 Sand Trap Court Salisburry Maryland Susan Silveria Clinton Wife Susan Silveria Clinton Susan Susan Silveria Clinton Susan Susan Susan Silveria Clinton Susan Silveria Clinton Susan Susan Silveria Clinton Susan Susan Silveria Clinton Susan Silveria Clinton Susan Susan Silveria Clinton Susan Susan Silveria Clinton Susan Silveri	11. Ma	Marital Status		12. Was Deced	ent Ever in U	.S. 13. \	Vas Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes	or No-				
Elementary/Beachdary (0-12) 12 College (1-tor 5-t) Doctor:				1 ☐ Yes 2	No	1				, 1 46110 1	moan, o	10.)				
Elementary/Secondary (0-12) 12 Sample College (1-4or 5-) Doctor Do	3 (Year or Dat	es:			••				-		711		
17. Father's Name (Prist, Middle, Last) 19. Michier's Name (Prist, Middle, Maddle Sumane) 19. Don'thy Fix 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Saite, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Saite, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Saite, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Saite, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mary Land (Sineer) 19. Mailing Address (Sineer and Number of Rural Route Number, City or Town, Sineer, Zp Code) 19. Mary Land (Sineer) 1						(Give	kind of wo	rk done d	lurina most	of workii	ng	1	6b. Kind of E	Business/fr	idustry	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maddle Sumane) 19. Donathon Fix 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zp Code) 19. Mailing Address (Sireet and Number of Rural Ro	Eler		1-12)		lor 5+)			30 / 31// 30/	,				- [~:~+		
The state of the s			iddle, Last)			DOCLE	<u>) L</u>		18. Mothe	r's Name	(First, I					
13e. Informants NameRelationship (Type, Print) 13e. Mailing Address (Simet and Number or Rural Route Number, City or Town, State, Zie Cote) 200e. Place of Desposition (Name of Desposition (Name) 200e. Place of Desposition (Name) 200e. P	Wi.	illiam	Louis	Cli	inton				Joa	an	D	orotl	ny	Fix		
Committee Comm		Informant's Name/Rei	ationship (T)	rpe, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	l Route	Number,	City or Town	, State, Zij	Code)	
1 Burial 2 Coremation 3 Removal from State Committee C	Su	ısan Silver	ia Cl	inton -					cap Co	ourt,	, Sa	lisb	ary, M	aryla	and 21	30.
A Donation Soliter (Specify) Salisbury Crematory 9.23.20 Salisbury Mary Mary Salisbury S			ation 3 DE	Removal from St	ate	semetery, cren	natory or o	ther place						•		
23. Part. Enter the disease, or complications hat caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, and proposed or heart failure. List only one cause on each time. Atherosclerotic cardiovascular disease Atherosclerotic cardiovascular disease					Sa	lisbury	Cre	mator	y 9.	.23.20	005		Salisb	oury,	Maryl	an
23. Part. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents the mode of dying, such as cardiac or respiratory arrest, and contents and contents the mode of dying, such as cardiac or respiratory arrest, and contents are dispirated as a consequence of): Part In the past 2 content 23c. It yes, outcome of pregnancy 23d. Date of delivery 23d. Date of deliv	21.5	ature of Funeral Se	rvice Licens	800		22 F.		d Addres	uner	ál Ho	ome,	Pro	fessio	nal A	Associ	at:
shock, or heart failure. List only one cause on each line. Atherosclerotic cardiovascular disease restricting in death) Between the property of the property	7	James 9	le U											aryla		
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown 2 Felat death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day 1 yes 2 No 9 Unknown 2 No 3 Probably	resulti	initiated events	₹	Due to (o												
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown 23d. Date of delivery Month Day 23d. Date of delivery Day 23d. Date of delivery Month Day 23d. Date of delivery Day 23d. Date of delivery Month Day 23d. Date of delivery			•	d												
225. Was case referred to medical examiner? 226. Place of Death (Check only one) 227. Was an autopsy find yes 2 No 1/2 / Yes 2 No 1/	IF FEI 23b. V	Was decedent pregna in the past 12 months	316	1☐Live bir 4☐Pregna	th 2 ☐ Feta nt at time of d	t death 3									-	Year
25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 24a. Was an autopsy fine prior to completion death of the examiner? 1 Yes 2 No 3 Probably 24a. Was an autopsy fine prior to completion death? 1 Yes 2 No 3 Probably 25. Was case referred to medical examiner? 1 Xes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Impatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) At 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 3 Probably 24a. Was an autopsy fine prior to completion death? 1 Xes 2 No 1 Yes 2 No 25. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 2 No 2 No 28a. Date of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yes 20d. Date signed (Month)	=					···										
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Naturat 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and, title of certifier 29b. Signature and, title of certifier 29b. Signature and, title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day Year)	Part II.	II. Other significant co	enditions co	ntributing to dea	th but not res	ulting in the ur	iderlying c	ause give	n in Part I.		236		_			
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) at 1 Nanner of Death 1 Naturat 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day,											24a	autopsy		prior to co	psy findings mptetion of a	ava
25. Was case referred to medical examiner? Notice Work Accident Check only one Pending investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)											100			death?	2□ No	
27. Manner of Death 1) ex	xaminer?	-	dospital:				104		of Death	(Check	only one,				
1 X Natural 2 Accident 3 Suicide 4 Homicide See Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State) 29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20c. M.E. September 23, 20c.	1			. 1 ∐ [n]				77	4 🗀 1901						_{y)} at so	:er
29a. Certifier (Check only one) 29b. Signature and, title of certifier 29b. Signature and, title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Ye.)	1) 2(XNaturat 5 ☐ F 2 ☐ Accident ii 3 ☐ Suicide 6 ☐ 0	ould not be	(Month	Day Year)	Injury	М	1 🗆 ١		40					A Poute No	has
Thoda M. K. September 23, 20		- Homicide		building	g, etc. (Specil	(y)					City	or Town,	State)			
Thoda M, Ly and O.C.M.E. September 23, 20		(Check only 2X Me	dical Exami	ner: On the bas	is of examina	wiedge, death ition and/or inv	occurred restigation	at the tim	e, date and pinion, deat	d place, a th occurre	ind due ed at the	to the cau time, dat	ise(s) and m e and place,	anner as s and due t	tated. the cause(;)
I work to the total		Signature and title of o	ertifier	V1			290			7						:
20 Name and address of parcon who completed the of death (from 22a) (Type Print)		Theode	nel,	Ky	, ans			0.	C.M.F	5.		Se	eptembe	er 23	, 2005	,
THEODOM McKarg 111 Penn Street, Baltimore, Maryland 21201	30. Na	_			of death (Iter		•									

State of Maryland / Department of Health and Mental Hygiepe005Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** September 13, 2005 Dorothy L. Cooper 2:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1100 S. Schumaker Drive Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X F 214-10-8274 92 Yrs Director 10/13/1912 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 le marked other then "natural", or Iteme 23a or 28a-f eho other traumatic event, the Modical Examinal must be notified at Yes 2 No Maryland Wicomico Directo Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 S. Schumaker Drive 21804 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after reent of Health and Mental Hygiene. ent: If Item 27 le marked other then "natural; or flee ury or other traumatte event, the Manifal Exercities ury or other traumatte event, the Manifal Exercities. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Everett Ambrose Larmore Blanche Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 S. Schumaker Dr., Salisbury, MD 21804 Philip Cooper/husband 20b. Place of Disposition (Name of commetery, crematory or other place)
Wicomico Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny injury or once. 9/16/05 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility
HOIloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Athero Sclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 🗀 Unknown sete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 2 8 24a. Was an autopsy performed? 1 ☐ Yes 2 12 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠ No Insufficiency certificete has Hospital or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient ihis 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death.

Director: All d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fund completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DZ4986 14/61 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Keilly MD 560 Riverside On BIOI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For State Registrar	State of Maryland /		artment of F			giene 005	5 31530
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Ye	3. Time of Death
	/Medic		Robert Edward Conw 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death	August	31, 2005 4c. County of D	
	Funeral Director	*	0/9-12-525/		birthday) Yrs.	Silver S If Under 1 Year Months Days		8. Date of Bin (Month, Da April 2	Montg th y, Year) 9. 21,1918 Ne	Birthplace (State or Foreign Country)
	yland		Usual Residence of Decedent 10a, State 10b, County	10c. City, To	wn or Lo	cation		-		10d. Inside City Limits
	the Mar	Director	Maryland Prince Geo	orge's Ad	le1pl	10f. Zip Code			10g. Citizen of What	1 ☐ Yes 2 ☑ No
	h with		1733 Metzerott Roa	ıd		10. Lip 0000	20783		USA	oody.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injuryogopher traumatic event, the Medical Examinar reast be notified at once.	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1	-	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - A Black, W Specify:	American Indian, Vhite, etc. White
21215-0036	n 72 ho n *natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	tent's Usual Occup kind of work done OO NOT use retired	during most of wor	king	16b. Kind of Busine	ess/Industry
212	giene, grene, er than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		lonary Br	Ĺ.,		Religio	n
and	a be file intal Hy ed oth	Be	17. Father's Name (First, Middle, Last)	_					Maiden Sumame)	
Maryland	should and Me s mark	T ₀	Dennis Conway 19a. Informant's Name/Relationship (Type		9b. Mailin	g Address (Street	Elizabe and Number or Ru		ahoney er, City or Town, Stat	'e, Zip Code)
ore, M	of Health		Richard McCann, S	.T. 1	733 I	Metzeroti sition (Name of natory or other plac Ltan	t Road A		Maryland 20c. Location - City	20783
Baltimore,	it. Pag rtment rtent: b njury g		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licental			rematory Name and Addre	Sep.	3,2005	Alexandri	a,Virginia
Ba	Depar Impor any ir		23a, Part1, Enter the disease, or complic	Jack	Fr 50	ancis J. O Univers	Collíns sity Blvd	.,W.,Si		ng, MD 20901
	Pnysician		shock, or hear failure. List only on Immediate Cause (Final disease or condition	e cause on each line. Subdural Hemat			•	от тооринатогу оп		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence		NOII-114	amacic			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	e of):	7		1		mome
8760,	death certificate be executed e attending physicien and by for use as the burial-transit	Ical Exa	resulting in death) Last	Due to (or as a consequence	e of):		\		No In	
9	ertificat ling phy e as th		IF FEMALE:	0. 16			1 2	1	70 00 0	13 05
.O. Box	at the death certific by the attending p tached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	. Or	* All	23d. Date of Month	Day Year
ecords, P	signed be de	by	Part II. Other significant conditions con	tributing to death but not resulting	j in the ur	nderlying cause giv	ren in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
$\mathbf{\alpha}$		Completed							an 24b. Were prior death 2 No 1 1	
Vital	ysician: Tr is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	lospital: 1 🔀 Inpatient 2 🗆 ER/0	Outpation	t 3 DOA Oth	26. Place of Dea		ne) dence 6 □Other (5	Engelist)
ion of	ding Ph	H	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injur Wor			now injury occurred	респу
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (5 City or Tox		r Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical (sician: To the best of my knowled ner: On the basis of examination and manner stated.						
	To the He within 24 To tha Fe completel	Ž	29b. Signature and title of certifier	() MON	>	29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
1	6		30. Name and address of person who do	mpleted cause of death (Item 23a	a) (Type.		0791		September	
			Damirez T. Fosset		edic	al Park I	Orive #10	0 Sil	ver Spring	MD 20902
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 4 200)5 Samegistrar's Signature	GO	MEL				

¢ 05	-06348						. Ensure All			
Apri	1 Dawn	Ca	mpbell 1- State Unpend Item	State of Ma 23a,27,28a	aryland / Depa -f per me	artment of I	lealth and Me Death Death	ental Hygi	ene 2005	31531
*	Physici		Decedent's Name (First, Middle, La: APRII		CAMPBEI	L		2. Date of Death Month Septemb	per 17, 200	3. Time of Death 05 4:23 A M
	/Medio	44	4a. Facility Name (If not institution, giv-			4b. City, Town,	or Location of Death		4c. County of Dea	
			3506 Parkway Teri			Suitlar			Prince (
	Funeral Director		215-06-2179	ex 7. Age ☐ M 2(X)F	36 (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, MARCH 9	,1969 MA	thplace (State or Foreign ountry) ARYLAND
39	aryland •how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many	to	MD. PRINCE G	EORGES	CA	APITOL HE	IGHTS			1X Yes 2 No
	with the Marylan a or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	death with the Maryland ms 23s or 28s-1 show frout be rediffed at	ra	5601 HIGHMOUN	T			.0743	7 N - 1 N	U.S. A	
		Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 □ Yes 2 🔀 N		was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec Jan, Mexican, Puerto R	ican, etc.)	Black, Whi	
920	hours after death v urel', or Items 23c	by	3 ☐ Widowed 4 【Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	HITE
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation de com <i>pleted</i>)	(Give	dent's Usual Occu	during most of workin	9 1	6b. Kind of Business	/Industry
121	d within giene. r than "	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire			ELOOD (10
2		e Co	12 17. Father's Name (First, Middle, Last,)		LABOR	18. Mother's Name	(First, Middle, M	FLOOR (.0.
an	<u>a</u> o a a a	To Be	THURMAN		INER		Н	AZEL	MORRIS	
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	t and Number or Rural	Route Number,	City or Town, State,	Zip Code)
	and 2 salth a n 27 l		HAZEL CONNER/	MOTHER			FERRY RD.			
ore	Pages 1 and 2 nent of Health a nort of Health a nort. If Item 27 le		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other pla			20c. Location - City or	Town, State
Baltimore,	T = C		4 □Donation 15 □ Other (Specifical Service Licenters)		CHAMBERS				RIVERDALE,	
Bal	permit. Departm Importe eny Inju		21. Signature of Fundad Service Lios	amberra	2 _{м00091} СТ	IAMBERS F 301 CLEVE	UNERAL HOM LAND AVE.,	E & CRE RIVERD	MATORIUM, E ALE, MD. 2	O737
	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Narcotic Due to (or as	and alcohe a consequence of):			respiratory arre	st,	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
P.O. Box 6	requires that the death certificate teen signed by the attending physic hould be detached for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	ivery Day Year
	ires that signed t d be det	l by P	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the u	nderlying cause gr	ven in Part I.		accoluse contribute to	o the cause of death?
Sor	> 0 0	letec						24a. Was an	24b. Were au	Itopsy findings available
Vital Records,	The la ate has page 2	Сошр						autopsy	prior to	completion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	26. Place of Death			Caana
Division of	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur	v 28b. Time o	f unk 28c. Inju	4 Indiang Flom		nce 6 Other (Spe w injury occurred	unk
Divisi	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: Atter completely filled in by the tuner	Certification:	2 Accident Investigation 3 Suicide 6 Accould not be determined	e 29a Place of lair	ury - At home, farm, sti c. (Specify)			Bf. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number, unk
	• Hospital 24 hours a • Funerel C letely filled	Medical (examination and/or in		ime, date and place, ar opinion, death occurre			
	To the within To the comple	Me	29b. Signaluse and title of certifier	_		29c. Licen	se number	29	d. Date signed (Mont	h, Day, Year)
			16 Certen	4		00	CME		Septembe	er 17, 2005
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,		D 1. '	34 -		,
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra			Baltimore,	Maryla	nd 21201	
	Registr	-		005	JE Ap	sele)				

	06203 tor Man		-Garcia Contreras 1- Stata Registrar	Type or Print in B State of Maryland	d / Dep		leaith and M	ental Hy	_	
			Hegistrar Decedent's Name (First, Middle, La	st)				2. Date of De	ath	3. Time of Death
	Physic		Victor Manuel Ga	arcia Contreras				Sentem	ber 10,200	
	/Medi Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death	<i>версен</i>	4c. County of De	
1	Exami		University of Mar	vland Shock Tr	auma	Baltimore	e			
	Funeral Director		5. Sociaf Security Number 6. S		ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07-16-	th y, Year) 9. E -1982 E1	sirthplace (State or Foreign Country) Salvador
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28a-1 ehow he Modical Examinar must be notified at	tor	Usuel Residence of Decedent 10a. State 10b. County D • C •	10c. City	, Town or L	ocation Washingt	ton			10d. Inside City Limits ↑ Yes 2 □ No
	r 28a	Director	10e. Street and Number		·	10f. Zip Code			10g. Citizen of What	Country?
	h with	a D	5601 13th Street	, N.W. #109		2001	11		El Salvad	or
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No Rican, etc.)	- 14. Race - Ar Black, W	nerican Indian, hite, etc.
9036	ours after death with the Maryla ral', or Iteme 23a or 28a-1 ehov Examiner must be notified at	þ	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 XYes 2 No				
215-0	hin 72 hours 8. 9n "natural", Medical Exe	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of worki d)	ng	16b. Kind of Busines	
21	ygiene /giene er the	Con	4		Labo	rer				ion Company
Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natur eny Injury or other treumatic event, the Medical eny Injury or other treumatic	To Be	17. Father's Name (First, Middle, Last, Juan Contrera Jua	ares			Santos C	olonbi	Maiden Sumame) na Garcia	
Man	and 2 sho alth and 1 27 le mu		19a. Informant's Name/Relationship (Jose Francisco Co	Type, Print) (cousin) ontreras			and Number or Rura ve irginia,		er, City or Town, State	a, Zip Code)
re,	of Her Item		20a. Method of Disposition	CC	ace of Disp	osition (Name of matory or other place	ce)	ate	20c. Location - City	
Ē	Page nent o		1 X Buriaf 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the cont		ily C	emetery	09-2	2-2005	El Salvado	or \
Baltimore,	permit. Departn Importa eny Injk		21. Signature of Funeral Service Lice	Bacon 10 36					Funeral F hington, I	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only fmmediate Cause (Finaf disease or condition resulting in death)	one cause on each line.	1000	iter the mode of dyin	ng, such as cardiac c	r respiratory a	rrest,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentiafly list conditions,	b. Due to (or as a consequ						
	and transit	ramlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) I ast	c						
68760,	ficate be exec physician ar s the burial-ti	Ilcal E	resulting in death) Last	Due to (or as a consequ	ence or).					
P.O. Box 6	ne death certii the attending hed for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. ff yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of o	defivery Day Year
	quires that the signed by and be detacted	ed by Pl	Part ff. Other significant conditions	contributing to death but not resu	Iting in the u	underlying cause giv	en in Part I.		1 /	to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law require te has been si age 2 should b	Completed						24a. Was autor perfo	an 24b. Were prior to death	autopsy findings available ocompletion of cause of ?
ita	ysiclan: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?				26. Place of Death	(Check only o	one)	
}	hysic his ce i direc	To	1 TYes 2 No	1		nt 3□ DOA Oth	er: 4 🗆 Nursing Ho		dence 6 Other (S	pecify)
u 0	ding Phy h. After thi funeral c		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Wor	yat	28d. Describe	how injury occurred	
Sio	leath. tor: Aff	Certification:	2 Accident investigation	10201	8:301					2; Rouge o von
Š	or Att	ŧ	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify		treet, factory, office		City or To	Street and Number or wn, State)	
	o the Hospital or Attendi thin 24 hours after death. I the Funeral Director: A mpletaly filled in by the fu		On Continue 4T 2 14 1	ροδου		***				5 TA-BOTLO LUD
	Hos 24 ho Fund Itely f	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Madical Examone)	nysician: To the best of my know minar: On the basis of examinat and manner stated.	wiedge, dea ion and/or it	th occurred at the tir nvestigation, in my o	ne, date and place, a pinion, death occurr	ed at the time,	date and place, and d	ue to the cause(s)
	the the	Je.	20h SignAture and title of certifier	and mainter stated.		29c. Licens	e number		29d. Date signed (Mo	onth Day Veer

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANUALLY A (ORGAN)

31. Date filed (Month, Day, Year)

SEP 1 5 2005 111 Penn Street, Baltimore, Maryland 21201 22. Registrar's Signature Speck

ORIGINAL

O.C.M.E.

September 11, 2005

			For State Registrar	State of M		epartmen Certificat				Re	g. No.	31533
	Physici	an	1. Decedent's Name (First, Middle, NARCISA DE JESU	•	STR0					Date of Death	ER ^{ay} 11, Ž ũ	3. Time of Death 10:04РМ м
	/Medic Examin	_	4a. Facility Name (If not institution, National Insti	•			Town, or	Location of	Death		4c. County of De	
Ī	Funeral Director		5. Social Security Number None	6. Sex 7. Ag	je (In yrs. last birt			If Under 2 Hours	Min.	Date of Birth (Month, Day, eb. 15	Year) 9. B	irthplace (State or Foreign Country)
	D.	}	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	n or Location						10d. Inside City Limits
	e Maryl	ctor	Ecuador		Cuenc			<u>.</u>				1 ☐ Yes 2 🖾 No
	with the	Dire	10e. Street and Number	:1 w .		10f. Zip				10	g. Citizen of What (Ecuador	Country?
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "netural", or items 23a or 28e-1 show event. The Medical Exarti at must be trofified at	by Funeral Director	Ave. 12 DE Abr: 11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		Non 13. Was Deced If Yes, spec	dent of Hi cify Cuba		in? (Specify Puerto Rica Ccuado		14. Race - An Black, Wh	nerican Indian, nite, etc. spanic
21215-0036	vithin 72 hou ne. han "neture e Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College (1-4or		Decedent's Usua (Give kind of wa life. DO NOT u	rk done a se retired,	luring most)	oi working	1	6b. Kind of Busines	s/Industry
and 2	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, I	•		омешр.	Loyec	18. Mother			faiden Surmarne) Castro	
Maryland	2 2 3	F	19a. Informant's Name/Relationsh	ip (Type, Print) HUs	Spana	•					City or Town, State	Zip Code)
	ages 1 and 2 nt of Health I: If item 27 or other tre		Simon Alfredo M 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20h Place of	e 12 DE Disposition (Nai ry, crematory or o De La nza	na of	I	Date 09-21-	0.5	, Ecuador	
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or of		21. Signature of Funeral Service L		Espera	22. Name ar	nd Addres	s of Facility	Marsh	all's	Cuenca, E Funeral He ton, D.C.	ome
	cate be executed / Medical Examine and / Mentar-Iransit ithe buriar-Iransit	Examiner	23a. Part / Enterthe disease, or shock or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c	d the death. Do rine.	Hypolical Hypoli						Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 ments? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	2 Fetal death	3 ∐Ectopic p 5 □ Other (sp					23d. Date of d Month	elivery Day Year
ds, P	ires that signed b	by	Part II. Other significant condition	ns contributing to death t	out not resulting in	n the underlying o	ause give	en in Part I.		23e. Did tob	/	to the cause of death? Probably 4 □Unknown
of Vital Records,	The taw requir cate has been si page 2 should	Completed	Acute Per	al Fail	ure					24a. Was an autopsy perform	/ prior to	
Vita	icien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	- STE	1000	heck only one	1 M 1 10 - 10 10 0	1000 1
on of	ding h. After fune	ıtlon: To	1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Injui	ury 28b. 1		28c. Injury Work	4 🗀 Nur	28d		nce 6 Other (Sp w injury occurred	өсіту)
Division	ē ģ ģ ⊑	Certification;	3 Suicide 6 Could r 4 Homicide determi	ned 200. Place of III	jury - At home, fa tc. <i>(Specify)</i>	rm, street, factor	y, office		28f.	Location (Str. City or Town,		Rural Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical (g Physicien: To the best Examiner: On the basis of and manner s	of examination an							
1	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Barnett	•		c. License	1892		29	Od. Date signed (Mo.	
2	0		30. Name and address of person	who completed cause of	death (Item 23a) 10	(Type, Print) O CENTER	DRI	VE, B	ETHESI	DA, MD	20892	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 5 2	26 Doniet	rar's Signature	Specie						

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment o ertificate	f Health and of Death		gien 2 0 0 5	31534
	· Physici	an	Decedent's Name (First, Middle, Last)	_				2. Date of Dea Month	Day Yea	
	/Medic	cal	Anna Ruth Dai			4h City Tou	m, or Location of Deat		ber 12, 20	005 2340 M
	Examir	ner	4a. Facility Name (If not institution, give Carroll Hospital				estminster	111	Carr	
€,	Funeral		Social Security Number 6. Se	x 7. Aç	je (In yrs. last birthda)) If Under 1 Ye			h 9.F	Birthplace (State or Foreign Country)
	Director		217 20 3273]M 2√ΩF	77 Yrs.	I I I I I I I I I I I I I I I I I I I	ly Tiours	Nov 18,	1927 M	aryland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary Ind :	ţō	Maryland Carrol	L1			Westmins	ter		1 ☐ Yes 2 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, Ite Medical Examinational be neitlied at	I Director	10e. Street and Number 1010 Tracy Meadow	vs Drive		10f. Zip Cod	21158		10g. Citizen of What USA	Country?
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
36	or It	by Fu	1 Never Married 2 Married	1 ☐Yes 2 ☑ If Yes, Give		1 ☐ Yes 2 ∑		,	Specify:	white
21215-0036	tural'	ed b	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dec	edent's Usual Oc	cupation		16b. Kind of Busine	ss/Industry
215	nin 72 in "na Medic	plet	(Specify only highest grad		(Giv	e kind of work do DO NOT use re	one during most of wo atired)	rking	Surety a	,
	ad with	Completed	11			Self Emp			Bonding	
Maryland	4.2 should be filed within " h and Mental Hygiene." 7 is marked othar than " traumatic evant, the Mes	Be	17. Father's Name (First, Middle, Last) Edgar Smith Shar	nka				, ,	Maiden Sumame)	
ryla	d Mer narke natic	ဥ	19a. Informant's Name/Relationship (T)		19h Ma	ling Address (St.	reet and Number or R	a Cockrui		Zin Code)
Ma	and 2 salth an n 27 is refer traus		James C. Knights,			-	an Creek R		-	
re,	other	1 4	20a. Method of Disposition	···	20b. Place of Disposemetery, cr	oosition (Name o	of place)	Date	20c. Location - City	or Town, State
imo	Pages ment of ant: If its ury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Manchest	-		.6/2005	Manchest	ter, MD
Baltimore,	pernit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		21. Signature of/Fugreral Service Licens	MO	6723 Ms		ddress of Facility th Main St		neral Home ead, MD 21	
	0.5		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause ne cause on each I	d the death. Do not e	nter the mode of	dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ver	Hickar	Tach	y Cardia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	Cod	y Cardia	1.		16.000
		P.	Sequentially list conditions,	D	a consequence of):	Cerran	10 195 Cler	mean	۷	1947
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	e exectian an	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	dlcal	(d						
9	leath certific attending p	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of	deliven
Вох	that the death cer ed by the attendir detached for use	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	☐ Ectopic pregn☐ Other (specify			Month	Day Year
P.O.	t the c by the tached	hys	9 Unknown	9□ Unknown						
	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by	Part II. Other significant conditions co	ntributing to death t	out not resulting in the	underlying cause	e given in Part I.			to the cause of death? Probably 4 Honknown
Örö	requi	eted						24a. Was		autopsy findings available
Records,	sician: The law certificate has t irector, page 2 s	Completed						autop	sy prior t med? death	o completion of cause of ?
Vital		0	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o	2 ☑ 1 ☐ Y	es 2⊡+Mo
ſΫ́	Physician: this certifical	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 (Inpati	ent 2 ER/Outpati	ent 3 DOA	Other: 4 Nursing	Home 5 Resid	lence 6 □Other (S	pecify)
n of	ing Phys		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injury		Injury at Work?	28d. Describe h	ow injury occurred	
sio	Attending it death. sctor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Place of le	iuns. At hama farm		1 ☐ Yes 2 ☐ No	28f Location /6	Street and Number or	Rural Route Number,
Division	after of Dirac	Certification:	4 Homicide determined	building, e	jury - At home, farm, s tc. (Specify)	street, factory, on	rice	City or Tow		ndiai noble Nulliber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical C		iner: On the basis of	of my knowledge, de of examination and/or					
	o the ithin 2 o tha omple	Med	29b. Signature and title of certifier	and manner si	ateu.	29c. Lie	cense number		29d. Date signed (Mo	onth, Day, Year)
				10		t	52035		Sen	13 2005
20	2 Jahr		30 Name and address of person who c			e, Print)	52035 Werming	11	0 21110	
4			BINU CHACICO	291 5	toner Aven	nee	Werkning	he 1	0 21157	
192	Sta Regist	ate rar	31. Date filed (Month, Sar Year) 5	2005 32. Regat	rar's Signature	Sperte	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiere 0.05 3.1535

			For State	<u> </u>	Department of Health and I Certificate of Death			31333
	2 1	?	Registrar 1. Decedent's Name (First, Middle, Last		Continuate of Death	2. Date of Death		3. Time of Death
TA.	Physici		VERGIE LED	NARD DEN	RIG	Month 10	2005	1336 M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	h	4c. County of Death	
		3	Peninsula legior	ral Medical Cent	er Salisbury		Wicomic	
	Funeral		5. Social Security Number 6. Se	711 0575	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Yea		ace (State or Foreign
198	Director		2/3-16-4669 1L Usual Residence of Decedent	13		1-4-1	12	// C
	yland how		10a. State 10b. County	10c. City, Town	n or Location		10	d. Inside City Limits
	e-fall	ctor	Mb Wicon	mico)	DELMAR			1 Yes 2 □ No
	or 28	Dire	10e. Street and Number	Consider	10f. Zip Code	10g.	Citizen of What Count	ry?
	seth v	Funeral Director	1301-PINE	12. Was Decedent Ever in U.S.	21875	Specify Yes or No-	USA 14. Race - America	ın Indian,
	ther de	Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2★No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, e	tc.
036	72 hours after deeth with the Maryland natural; or Items 23a or 28e-f show areal Exeminar must be notified at	र्व	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ZNo Specify:		Specify: BI	LACK
5-0036	72 hc	Completed	15, Decedent's Edi (Specify only highest grad	ucation 16a. de completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business/Ind	ustry
121	within ene. then "r	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	<i>i</i> . \	A.	1= 11 ano (PRICIPAL
CA	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last)		LINE WORKER 18. Mother's Na	me (First, Middle, Maio	1ERICAN (len Sumame)	PRIGIPAL
an	ould be filled with Mental Hygiene arked other thai atic event, the	To Be	WILLIAM	MITCHELL	LILL	AN MI	TCHELL	
Maryland	and Men ts marke		19a. Informant's Name/Relationship (T	ype, Print) 19b	. Mailing Address (Street and Number or R.	ural Route Number, Cit	y or Town, State, Zip	Code)
-	1 end 2 Health em 27 l			15~500	301- PIDE STREET,.	DELMAR, N	D 2187	15
Baltimore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State cemeter	Disposition (Name of ry, crematory or other place)	Date 20c.	Location - City or Tov	vn, State
Ë	permit. Pag Department Importent:: any Injury o		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License	111010		19 105 VI	ENNA, M	10
Ba	permit. Pages Department of Importent: If I any Injury or one		To Esculla	2 Krings		ST. SALI	SMITH F	14
	THE T		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the death. Do	not enter the mode of dying, such as cardia	c or respiratory arrest,	3 130/29/11	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	exami cardio ua	Scallare	DIGIASE	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence			70-770	
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	of):			
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	or):			
I_^	al-tran	Examiner	that initiated events resulting in death) Last	c	of):			
68760,	icate be executed physicien and s the buriat-transit	edical	(d				
	.= On os		IF FEMALE:				l .	
Вох	death certiff e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of deliver Month	'Y Day Year
	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			
P.O.	res that the de signed by the a be detached f	'Ph	Part II. Other significant conditions co	ontributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
rds	w requires been sign should be	ed by	CVA			1 🗆 Yes	2 ☐ No 3 ☐ Proba	ably 4 Donknown
000	Z 45 75	plet				24a. Was an autopsy	24b. Were autop	sy findings available
Ä	The law	Completed				performed 1 ☐ Yes 2 ☐	? death?	
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital		ath (Check only one)		
of	S & D	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ot 28a. Date of Injury 28b.		Home 5 Residence)
on	fer fer	tion	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,	
Division of Vital Records,	Attending in death.	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	arm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural	Route Number,
ā	s afte el Dir	Certification:	4 Homicide	building, etc. (Specify)		Only of Town, St	aroy	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	(Check only 2 Medical Exam	niner: On the basis of examination ar	e death continued at the time; date and place ad/or investigation, in my opinion, death occ			
	thin 2 of the omplet	Med	one) 29b. Signature and title of certifies	and manner stated.	29c. License number	29d.	Date signed (Month, I	Day, Year)
	F ≯F ŏ		> Wignin Up	aull on	D 32014	9	114/05	
			30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)	-		4.001
			MAHESH MOO	UDEA 106 Will	(Type, Print) and St Soil B	salisbury	1110 218	504
	St Regist	ate	MAHETH MODES 31. Date filed (Month SEP 152	32. Agistrar's Signature	Acres 10	/		

٠.	** ,		State of Ma	aryland / Depa			-	_	
			1-Stete RegistrerAmended item #26 per	•			-05/dls=	g. N2 0 0 5	31536
	Physici	an	1. Decedent's Name (First, Middle, Last)	N TT			Date of Death Month	Day Yeer	3. Time of Death
н	/Medic		WILLIAM BRYAN DICKERSO		4b. City, Town, or L	castion of Douth	9/6/2	005 4c. County of Dear	⊥_335A
	Examin	er	4a. Fecility Name (If not institution, give street and number)						
	5		21121 NANTICOKE RD 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	WICOMI 9. Bird	hplace (State or Foreign untry)
	Funeral Director			31 Yrs.	Months Days	Hours Min.	10/23	/1923 MD	untry)
	faryland show	ō	10a. State MD WICOMICO	10c. City, Town or Lo	ocation				10d. fnside City Limits 1 ☐ Yes 2 ☐No
	28a-	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	3a or		21121 NANTICOKE RD		21814		U	SA	
	ms 2	Funerai	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec	cify Yes or No-	14. Race - Ame Black, Whit	
920	72 hours after death with the Maryland Insturel', or items 23a or 28e-f show disal Exantinet must be incitied at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ 1 □ Yes, Give 3 ▼ Widowed 4 □ Divorced Year or Dates:	N1 943		Specify:	noan, etc.,	Specify: WH	
20	s within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usuaf Occupati kind of work done du	ion ring most of working	1 1	6b. Kind of Business	
21	within ene.	μğ	Elementary/Secondary (0-12) Coflege (1-4or t	5+)	DO NOT use retired)			INDUSTR	
12			1 1 17. Father's Name (First, Middle, Last)	INDU	STRIAL E	MPLOYEE 8. Mother's Name		ANUFACTU	KING
and	be d la	Be	WILLIAM BRYAN DICKERSO	ON SR	['		JARRET	1199	
Ĕ	d 2 should th and Men 7 is marke traumatic	ပ္	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street an				Zip Code)
, Ma	s 1 and 2 s if Health an item 27 is i		JOSEPH DICKERSON SON	210	81 NANTI	COKE RD	BIVAL	VE,MD 21	814
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 □ Punial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	CEMETERY			oc. Location - City or YASKIN, M	
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	M	Name and Address ESSICK F	UNERAL		о вох 61	
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each fi	the deeth. Do not ent	TVALVE, M er the mode of dying,	such as cardiac or	respiratory arre	st,	Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition						Onset and Death
	/Medical Examiner	miner	resulting in death) Due to (or as Me Laurentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury)	a consequence of): Static m a consequence of):	nelanom	a / L	ung C	au co-	months
,092	ite be executed sysician and he burial-transit	icai Examin	that initiated events resulting in death) Last C. Due to (or as	a consequence of):		-			
P.O. Box 68	The law requires that the death certificate to the sace been signed by the attending physic age 2 should be detached for use as the to age.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant ar 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	uires that signed b	þ	Part II. Other significant conditions contributing to death be Diabetes a Anemia	0- 0	1	in Part I.		accouse contribute to s 2 □ No 3 □ Pr	the cause of death?
Records,	The law requir ate has been si page 2 should	Completed	diseas, osterarthrit	5	-		24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
_		Ö	25. Was case referred to medical			26. Place of Death	(Check only one		2□ No
>	yaiclan: is certific director,	0 8	examiner? . Hospital:	ent 2 ER/Outpatien	Other		./	ice <u>• 6 MOther (Spe</u>	HOSPICE
on of	ding Ph h. After th funeral	tion: T	27. Manner of Death 1 BNatural 5 □ Pending 2 □ Accident investigation	ary Year) 28b. Time of Injury	Work?		8d. Describe how	v injury occurred	,
Division of	i or Atter after dea Director i in by the	Certification:	3 Suicide 6 Could not be 28e. Pface of Inj	jury - At home, farm, str ic. (Specify)	reet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medicel Exeminer: On the basis of and manner st	f examination and/or in	h occurred at the time vestigation, in my opir	, date and place, a nion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. License r	number	29	d. Date signed (Monti	n, Day, Year)
	O-CM		pres Fin	1. 6	2005	7255	-	29-20	05
,	219		30. Name and address of person who completed cause of c	leath (Item 23a) (Type,	Print)	1600		1	
	, M		Muhammad Eigz M.D	830	chesalea	ke Dr.	Cami	ridge	05 MD 2 1613
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature					
	Registr	ar	SEP 1 4 2005	us. H. l.	Track,				

State of Maryland / Department of Health and Mental Hygiene 31537 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Lawrence H. Davis **Physician** 12:00P M September 12, 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George Laurel 15608 Bradford Drive If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□F 60 18, 1944 Rayne, Louisiana Director 452-72-2490 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or liema 23a or 28a-f ahow traumatic avant, " a Medical Expresse must be notified at Maryland Prince George Laurel 1 Yes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 United States 15608 Bradford Drive Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inforciant: if Itam 27 is marked other than "natural", or iter any injury or other traumatic avent, the Medical Exam 1 Types 2 No 1965
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Marned **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Entrepreneur 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Laudina John Davis, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20707 15608 Bradford Drive; Laurel, MD. Evelyn Carpenter/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1

Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery Sept. 16, 2005 Brentwood, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 11315 Lockwood Drive 22. Name and Address of Facility 21. Signature of Funeral Service Lice Wa. 20904 Silver Spring, MD. Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onsel and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) ed by the detached Physi 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops, performed? 215 No certificate has 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 20 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2730 University Bh 30. Name and address of person who completed cause Linda 31. Date filed (Month, Day, Year) State SEP 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:41 pm Shirley Beatrice Dillard Sept. 12, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner 3418 Curtis Drive Apt. # 508 Suitland Prince George 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 226-48-3285 67 June 1938 Virginia Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County ral, or items 23a or 28a-f show Exercit at must be notified at 1 XYes 2 No Maryland Prince George Suitland [] 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3418 Curtis Drive Apt. #508 20746 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other then "natural", or ite 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates ir then "nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) 12 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Dillard Mary F. Neverson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heath ar
Importent: if Item 27 is
any injury or other trau 1930 Cumberland Ave. Petersburg, Virginia 23805 Fred Dillard / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removat from State Sept. 17, 2005 Petersburg, Virginia South Lawn Cemetery ' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alexander S. Pope Funeral Homes, P.A. rette 5538 Marlboro Pike Forestville, Md. 08 Approximate Interval Between Onset and Death 23a. Part 1 Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atteroscherotic Cardiovascular Heart **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 Yes 2 XNo Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 2 ER/Outpatient P 1X Yes 2 □ No 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H005 Zers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001 1005 31. Date filed (Month, Day, Year) State Registrar SEP 1 5 2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiens, For State Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 12, 2005 **Physician** MARY LOUISE BUTLER EDELEN 9:07 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) JANUARY 12, 1941 **Funeral** Hours Months Days 1□M 2\ XF MARYLAND 217-36-8444 **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County iral, or Items 23s or 28s-f ahow Examiner rupi by nutilised at 1X Yes 2 □ No Director MARYLAND CHARLES INDIAN HEAD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20640 124 WOODLAND DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 X Divorced If Yes, Give ** Year or Dates: "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other than PRESSOR CLEANERS 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES EARL BUTLER MARY ELSIE HICKS BUTLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 124 WOODLAND DRIVE, INDIAN HEAD, MARYLAND AUDREY CUTCHEMBER / SISTER Health tem 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. IGNATIUS CEMEIERY SEPTEMBER 19, 2005 CHAPEL POINT, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Shaper of Funeral Service Licensee

LEDIA C. THORNION JOHNSON MO0583 THORNION FUNERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused ine. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio myo pothy Priysician mic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con uence of): Examine The law requires that the death certificate be executed ection attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 24 hours after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 019518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 OLD BRANCH NECLOS ROSARIO istrar's Signature 32. Reistrar's Sig 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 1 5 2005

		For State Amond Thom	State of Maryland / Departs Per G847 9/29/49			2005 31560
Physi	ician	Decedent's Name (First, Middle, Last)	#J FEL GOAT 3/23/40	ygnout or Dourn	2. Date of Death Month	Day Year
/Med	dical	Mary C. Fender 4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Dea	Sept. 1	
Exam	nıner	Laurelwood Car		Elkton	au i	
Funera Directo		Social Security Number 6. Sex				Cecil 9. Birthplace (State or Foreign Country) 1925 Virginia
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	peation		10d. Inside City Limits
Maryl f sho	ğ	MD Cecil				1x Yes 2 □ No
h the	Director	10e. Street and Number	Elkton	10f. Zip Code	10g.	Citizen of What Country?
ath will	ralD	245 Locust Dri	ve	21921		J.S.A.
ING 21215-UU36 be filed within 72 hours after death with the Maryland ital Hyglene. Ital Hyglene in natural, or items 23a or 28a-f show event, the Modical Examinar roust be motified at	by Funeral		1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ➡ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0036 72 hours at 'natural', or dical Example	bed	15. Decedent's Educ	cation 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
21215 d within 73 glene. ar than "n.	Completed	(Specify only highest grade Elementary/Secondary (0-12) 8	College (1-4or 5+)	kind of work done during most of wo DO NOT use retired) ICtion	orking	Bata Shoe
be file that Hy of other	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	len Sumame)
irylar should be nd Menta marked matic ev	ဂ္	No information			ine Spark	
Mar Har 7 Is trau		19a. Informant's Name/Relationship (Ty) Mary Walter/ste		ng Address (Street and Number or R		
		20a. Method of Disposition	20b. Place of Dispo	Locust Lane,	Date 20c	ID 21921 Location - City or Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	erris, Inc. 200	t. 15, We	est Chester, PA
Baltimore, permit, Pages 1 ar Department of Hea Important: If item any injury or othe	ġ	21. Signature of Carberal Service License	98 22	2. Name and Address of Facility		
n gala	a	1 XXX	cations that caused the death. Do not ent	Andrew G. Gee		
Physicia	_	shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. Do not entine cause on each line.	er the mode of dying, such as cardia	ič of respitatory arrest,	Interval Between Onset and Death
/Medica Examine	r	resulting in death) Sequentially list conditions,	Due to (or as a consequence of):			VARNONA
ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Entire Turberlying Cause (Disease or injury	Due to (or as a consequence of):	11 -		
/60, te be executed ysician and e burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of):			ya Ku oun
2 8 € €	edical		Hyperetic			u., knows
at the death certifine by the attending processes as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
- 2 2 8	by Pt	Part II. Other significant conditions con	stributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
COTGS, P. w requires that is been signed b		wring tree	t infelio		1 🗆 Yes	2 No 3 Probably 4 Unknown
I HEC The law ate has b page 2 st	Completed				24a. Was an autopsy performed 1 Yes 2 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)
Of VITA Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	Othon	ath (Check only one)	
Physic ruthis oral d	n: To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of	28c. Injury at	Home 5 Residence 28d. Describe how in	
VISION C Attending P death. ctor: After t y the funera	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
S 5 5 5 5	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
To the Hospital o within 24 hours aff To the Funeral Di completely filled in	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the within To the	Σ	29b. Signature and title of certifier		29c. License number	29d. (Date signed (Month, Day, Year)
1		1 Am ear	1 1	D04823		9/14/05
~		Jui- Chin Hs	mpleted cause of death (Item 23a) (Type, ump 223w Ma	in St Elicton n	no 21921	r ·
S Regis	State strar	31. Date filed (Month, Day, Year) SEP 1 5 2005	32. Registrar's Signature	in St Elicton n		

State of Maryland / Department of Health and Mental Hygien U U 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept. 11, Diane Fitzgibbon Freeman 2005 9:55a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrest Hospice Ctr. @ GBMC Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Days **Funeral** Months Hours 1 ☐ M 2 🔀 F 219-90-2761 Director Dec. 21, 1963 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or then "natural", or iteme 23s or 28s-f ehow the Medical Exeminer must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 Holly Ridge Road 21146 USA by Funeral 14. Race - American Indian, Black. White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be ind Mental I Edward Fitzgibbon Alice Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Importent: if item 27 is any injury or other trau Peter Freeman/Husband 612 Holly Ridge Road, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Sept. 16, 1 DBurial 2 □ Cremation 3 □ Removal from State Annapolis, MD 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sofvice Licensee 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. ritchie Hwy, Severna Park, MD 21146 Janes 6 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List o'by one cause on each line. nmediate ause (Final isease condition sulting in death) **Physician** Yeavs Cholongio Carcikona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2.2.No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 2 110 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Sept, 11,2005 D006 1199 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NorthCharles St, Touson, MD 21204 6607 Slack Mr O 31. Date filed (Month, Day, Year) SEP 13 2005 Registrar

DHMH 17 Rev 1/2001

1,2005

#

RR

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

			1- State Amend Item 26 per verb., G847	gartment of Health and Nertificate of Death	Mental Hygie	n2005	31542
	Physici	30	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day_Year_	3. Time of Death
	/Medic		OLA MAE FLAHARTY		Sept.	17 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear	
	F		3310 Garrison Circle 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Abingdon y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		ford
	Funeral Director		187-24-1132 ^{1□ M 2} (Z)F 74 ^{Yrs.}	Months Days Hours Min.	(Month, Day, Ye	931 De:	thplace (State or Foreign buntry)
	ը _		Usual Residence of Decedent				
	anytar show	7	10a. State 10b. County 10c. City, Town or MD Harford Edg	ewood			10d. Inside City Limits 1 X Yes 2 □ No
	the M	ecto	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	
	with with	2	627 Banyan Road	21040	109	United	•
	ms 2;	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Madical Examinational by confilled at	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 6 No 1 Yes Give 1	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	Hican, etc.)	Black, Whit	White
5-0	72 ho natur	Completed	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work	ring 161	b. Kind of Business	/Industry
121	within ene. than	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) eteria Attendan	+ 12	larford	Co. School:
	e filed v al Hygie other t vent, in		8 Cal		e (First, Middle, Mai		co. School.
Maryland	ld be l ental l ked o	To Be	Fountain Green		1 Workma	,	
ary	2 should be and Mental Is marked (-		illing Address (Street and Number or Rui	al Route Number, C	ity or Town, State,	Zip Code)
	1 and 2 Health a tem 27 ls		Henry W. Flaharty, Jr./Son 3	310 Garrison Ci	rcle, Ab	ingdon,	MD 21009
ore	es 1 a of He fiter roth		1 M Burial 2 Cramation 3 D Removal from State cemetery, co	rematory`or other place)		c. Location - City or	Town, State
Ē	Pag ment ant: h		`4 □Donation 5 □Other (Specify) Union	Chapel Cem. 9/	21/05	Delta,	PA
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of once.			22. Name and Address of Facility Harkins Funeral	Home, I	nc., De	lta, PA
	3		23a Part 1. Enter the disease, or complications that caused the leath. Do not enough one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition a	muer			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
ı.		9	Sequentially list conditions, during to him adiate. b. Due to (or as a consequence of):				
	uted y ansit	Examiner	cause. Enter Underlying Cause (Disease or injury				
ó	cate be executed physician and s the burial-transit	Exa	that initiated events c. The sulting in death) Last Due to (or as a consequence of):	the state of the s			
68760,	ate be nysicia he bu	dicai	d				
	e as t		IF FEMALE:		· · · · · · · · · · · · · · · · · · ·	1	
Вох	death certifii e attending p id for use as	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death	∃ ☐ Ectopic pregnancy		23d. Date of del Month	livery Day Year
o.	0 0	ysic	1 Yes 2 No 9 Unknown	5 Other (specify)			
Δ,	requires that the been signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds,	quires n sigr uld be		Hypemension		1 🗆 Yes	2 □ No 3 ☐ Pr	robably 4 DUnknown
Record	> 17 0	Completed	Consonut of extension		24a. Was an	24b. Were at	utopsy findings available
Ä	9 4 9	шо			autopsy performed 1 ☐ Yes 2 ☑	d?/ death?	completion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)		Son's
of V	ys de s	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati				residence
on C	ling F. After une	ion	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28b. Time Injury (Month, Day Year)		28d. Describe how	injury occurred	
Division	eat or:	ficat	2 Accident investigation 3 Suicide 6 Could not be defended by the could no		28f. Location (Stree	et and Number or Ru	ural Route Number.
Div	- E E	Certification;	4 Homicide defermined 258. Place of Injury - At nome, farm, building, etc. (Specify)		City or Town, S		
ŕ	To the Hospitel c within 24 hours af To the Funerel D completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the caus	e(s) and manner as	s stated.
	in 24 in 24 ine Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To t To t	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
•			MI SW SMM MD	14642		114/05	
	10		-	n Avenue, Havre	de Grac	ce, MD	21078
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 8 2005	le			

			1 - For State Registrar	State of M	Maryland'/ Depa	artment of H rtificate of L			giene 0	05	315	43
	Physici	an	1. Decedent's Name (First, Middle					2. Date of Dea Month	Day	Year	3. Time of D	
	/Medio	al.	Michael Patric 4a. Facility Name (If not institution,		or)	4b. City, Town, or	Location of Death	9	13 4c. Count	2005 ty of Death	2053	М
	Exami	iei	404 143rd St.			Ocean Ci				ester		
	Funeral		5. Social Security Number	6. Sex 7 1★ M 2 F	Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6 / 12 /	h y, Year)		lace (State or	Foreign
	Director		220-76-8568 Usual Residence of Decedent	~	115.			6/12/	1959	<u> </u>	MD	
	thow	_	10a, State 10b, County		10c. City, Town or Lo					11	0d. Inside City	
	he Ma 28a-fs	Director	MD Worces	ster	Ocean C				10 000		XXYes :	2 No
	3e or	iDir	404 143rd St.			10f. Zip Code 21842			10g. Citizen of USA	vvnat Coun	itry ?	
	death	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spanic Origin?	ecify Yes or No-		ace - Americ		
36	s efter	by Fu	1)XNever Married 2 Marri 3 Widowed 4 Divorced		□ No		Specify:	110011, 010.7		_{ify} White		
9	72 hours effer death with the Maryland "natural", or Iteme 23e or 28a-f show idical Examiner must be notified at		15. Decedent	s Education	16a. Dece	dent's Usual Occupa	tion		16b. Kind of I	Business/Ind	dustry	
21	d within 72 giene. ir than "ne	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	kind of work done d DO NOT use retired)	uring most of work					
22		e Col	12. Father's Name (First, Middle, I	.ast)	Ba	rtender	18. Mother's Name		Hospit			
Baltimore, Maryland 21215-0036		To Be	George Thomas				Charlott					
lary	2 should be and Mental is marked reumatic ev		19a. Informant's Name/Relationsh	ip (Type, Print)		ng Address (Street a	nd Number or Rura	al Route Numbe	r, City or Towr	n, State, Zip	Code)	
e, s	1 and 1 Health em 27 ther tr		Kathleen Mary S	chultz (S1		Arundel R		dena, Md Date	20c. Location		wn State	
nor	Pages nent of I nnt: If its ury or o		1 ☐ Burial 2 【XCremation `4 ☐ Donation 5 ☐ Other (Sp			natory or other place Cremator	ı					
altii	permit. Page Department Importent: If eny injury or once.		21. Signature of Fulleral Sovice L		Day V TEW	. Name and Addres	s of Facility The	Burbag	Baltin e Fune	more, ral Ho	ma. ome	
8	8 9 E 8 8		1 Kom	Burb	De 11	08 Willian	n St., Be	erlin, M	ld. 218	11		
	*		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final						rest,		Approximate Interval Between Onset and De	een
	Physician /Medical		disease or condition resulting in death)		DIO Puumo as a consequence of):	NAM	FAILUR	20	-			
	Examiner		Sequentially list conditions.	b								
	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):							
Ć.	execu in and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	as a consequence of):							
8760,	cate be executed only sician and the burial-transit	lical		d								
9		an/Medical	IF FEMALE:	23c. If yes, outcon	ne of pregnancy				2015			
Box .	death certific ie attending p ed for use as	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Ye	ar
P.0	that the d ed by the detached	Physici	9 🗆 Unknown	9□ Unknown					1			
ທົ	Se un eq	by	Part II. Other significant condition D14 BETES		_	nderlying cause give	n in Part I.	23e. Did to	bacco use con es 2 X No	ntribute to the		
COL	> 0 0	ompleted						24a. Was a			sy findings av	
of Vital Record	The te h age	omo						autops		prior to con death?	ipletion of cau 2□ No	ise of
/ita	Physicien: This certificatal director, p	Be C	25. Was case referred to medical examiner?	11			26. Place of Death					
of		٦. ح	1 Yes 2 No	Hospital: 1 ☐ Inpa			4 Nuising No	me 5 Reside)	
ion	Attending Phir death. sctor: After thiby the funeral	ation	1 Natural 5 Pending investig	28a. Date of In (Month, E	Day Year) Injury	28c. Injury Work' M 1 □ Y	? es 2 □No	Edd. Boddingo III	on injury cood	1100		
Division	l or Attendater death Director: In by the	ertification;	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of I	njury - At home, farm, streetc. (Specify)	eet, factory, office	1	28f. Location (S. City or Town	treet and Num n, State)	ber or Rural	Route Numbe	ər,
	Hospitel or Atten 24 hours after deat Funerel Director: stely filled in by the	O	29a. Certifier 1 Certifying	Physician: To the he	at of my knowledge, death							
	호수구	edical	(Check only 2 Medicel E	xeminer: On the basis and manner	st of my knowledge, death of examination and/or inv stated.	estigation, in my op	nion, death occurr	ed at the time, d	ause(s) and m late and place,	anner as sta and due to	the cause(s)	
	To the h within 24 To the R complete	Me	29b. Signature and title of certifier	ATTON		29c. License			29d. Date signe			27
			- Xom	~'''	()		8700	•	Septer	nber	14,40	w
H	. 5		30. Name and Address of person v	tealthwa	death (Item 23a) (Type, Drive, Mar's Signature	Berlin H	1815 Qu	// Glenn	Arzado	n, M.[0.	
	Sta	1	31. Date filed (Month, Day, Year) SEP 1	2005 32.	mar's Signature	hardi o						
	Registr	ar	OLI I	1000	No 10 19	10						

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			eg. N2 0 0 5	31544
~		-	1. Decedent's Name (First, Middle, La	st)				2. Date of Dear	th Day Year	3. Time of Death
	Physicia /Medic		Alice	[nez	Goubeaux			Septembe		
	Examin		4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or	Location of Death		4c. County of De	ath
	. 4 %	***	11305 Bay Fr) If Under 1 Year	Lusby If Under 24 Hrs.	C Data of Bioth		vert
1	Funeral Director			Sex 7. A 1 □ M 2 ■ F	ge (In yrs. last birthday 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 22,	Year) 1927 0	irthplace (State or Foreign Country) hio
= =	D.		Usual Residence of Decedent		100 City Town and					104 India Ob 11 in
	anylar ehov	2	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ∰ No
	28a-1	Director	Maryland Calve	:t		Lusby 10f. Zip Code	7		log. Citizen of What 0	
	with	ā	11305 Bay Frony	A3702110			0657	'		-
	ns 23	Funeral	11.303 Bay Flong	12. Was Deceden	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	United St	nerican Indian,
21215-0036	72 hours after death with the Maryland netural', or Items 23s or 28s-f ehow deat Examiner must be mailfied at	þ	1 ☐ Never Married 2 ♣ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
9	natura	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	edent's Usual Occupa	ation	cina	16b. Kind of Busines	s/industry
21	within 7	nple	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)	ung		
	be filed within 72 ho stal Hygiene of other then "nature event, the Modical		12		Н	omemaker	10. Mathada Nasa	- /Fina Adidata	Own Ho	me
Maryland	2 should be find and Mental Hils marked otter	o Be	17. Father's Name (First, Middle, Last Grover S. Goodne						^{Maiden Sumame)} nda Johnso	n
7	s 1 and 2 should f Health and Mer Itam 27 is marke other traumatic	ဥ	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street a			r, City or Town, State,	
	D ≥ 2 +		Richard F. Goube	eaux / Hus	band 1130	5 Bay From	nt Avenue	Lusby,	Maryland	20657
ore,	ges 1 ar of Hea If Itam or other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Domayal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	θ)	Date	20c. Location - City of	or Town, State
Ĕ	Page: ment or ant; If I		4 □ Donation 5 □ Other (Speci		Forest H				Tipp City,	
Baltimore,	permit. Pages Department of I Important: If Its eny injury or of		21. Signatur of Funeral Service Lice	1					Funeral H	-
	0 □ E • 0		Edward N. Brinsi:							D 20650-0279 Approximate
			23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	iter the mode or dylin	g, such as carolac	or respiratory am	est,	Interval Between Onset and Death
200	Physician /Medical		disease or condition resulting in death)	a. Drea	ot cance					years
	Examiner			Due to (or a	s a consequence of):					
de-	as S.	Jer	Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of);					
	cuted nd ransit	Examin	that initiated events	c.						
ó,	e exe ian al urial-1	EX	resulting in death) Last	Due to (or a	a consequence of):					
8760,	cate be executed physician and the burial-transit	dical		_ d.						
9	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy				23d. Date of d	olivon
Box	atten atten I for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month Month	Day Year
0	that the de sed by the a detached t	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown						
S, P.	The law requires that the death certifi sie has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ord	v require been sig should b	ed t	Hypertension					1 □ Ye	es 2 XINO 3 □ F	Probably 4 □Unknown
Vital Records,	e law re has be je 2 sho	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
E.		Con						perform	med? death? 2≱No 1 □ Ye	
/ita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		th Check only on	18	
to	Phys this raldia	<u>۱.</u>	1 Yes 2 No	1 ☐ Inpat	ient 2 ER/Outpatie		4 Nursing H		ence 6 Other (Sp ow injury occurred	pecify)
	ding Ph h. After th funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year) Injury	Work	(? Yes 2 □ No	Edd. Ddddillod III	ow injury cocurred	
Division	Attend r death octor:	fica	3 ☐ Suicide 6 ☐ Could not t	28e. Place of Ir	jury - At home, farm, s			28f. Location (Si	treet and Number or I	Rural Route Number,
Ö	s afte s afte al Dire	Certification:	4 Homicide	building, e	tc. (Specify)			City or Town	n, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical (29a. Certifier 15 Certifying P (Check only one)	hysician: To the bes miner: On the basis and manner s	t of my knowledge, dea of examination and/or i tated.	th occurred at the time	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
	To thi Mithin To thi	Me	29b. Signature and title of certifier	0 1		29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
	1		Pole X Ist	la lage	(M)	016	823		9-20-0	5
•			30. Name and address of parent who	completed e of	death (Item 23a) (Type					
			Robert J. Schla			ital Road,	Prince	Frederic	k, Maryla	nd 20678
	- A	ite	31. Date filed (Month, Day, Year) SFP 2 0	2005 32. is	rar's Signature	Lack I				

State of Maryland / Department of Health and Mental Hygiene [] [] 5 31545 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thelma Dareen Hetrick September 14, 2005 1331 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2€ F Yrs 219-16-9205 Dec 8, Maryland Director 83 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. The Maryland Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Hampstead 1 ☐ Yes 2 ☒ No Maryland Director Carroll 10g. Cilizen of What Country? 10e. Street and Number 10f. Zip Code 1723 Cape Horn Road 21074 USA Funerai 14. Race - American Indian, Black, While, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. white δ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drug House Clerk 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rosabelle Bryant William Albert Manger ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Calp, daughter 2800 Treelin Drive, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 09/17/2005 Highview Memorial Fallston, MD 21. Signature of Furtheral Service Licensee M00723 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 Approximate Interval Between Onset_iand Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 2 days /Medical Due to (or as a consequence of) TRACT INFECTION Examiner RINAR Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, oulcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 pronths?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknow been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 20X No 1 ☐ Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 k Inpalient Medical Certification: To 2 ER/Outpatient 3□ DOA this funeral Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury al Work? 28d. Describe how injury occurred After or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after deat filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h Signature and title - rtifier 2 9/14/2005 D31660 tromas H. (Coluis MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2911 STOWER AVENUE WESTHINGTER MO 21157 TITOMAS GALVIN

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

15

32. Registrar's Signature

4	1		For State	State of Maryl		epartment of I Certificate of		nd Mental Hy			
_			Registrar 1. Decedent's Name (First, Middle, Las	er)		Jertinicate of	Dealii	2. Date of D	Reg. No	105	3 Tm 5 Day 6
	Physicia	ın						Month	Day	Yeer	7:30 A M
	/Medic	al	Lois Elaine Hunde			4b. City, Town,	or Logotion of	Sept.	8,	2005 unty of Death	7.50.7
	Examin	er				Sykesv		Death		roll	
			5810 Miriam Drive 5. Social Security Number 6. S		yrs. last birth			4 Hrs. 8. Date of B			place (State or Foreign
	Funeral Director			M STATE		rs. Months Days	Hours	Min. 8. Date of B	hay, Year) 1945	Cou	yiand
		-	Usual Residence of Decedent					oune 2	, 1777	Tiu1	yıanı
	yland		10a. State 10b. County	100	. City, Town	or Location					10d. Inside City Limits
	Mar.	to	MD Carroll	5	Sykesv	ille					1 ☐ Yes 2 💢 No
	r 28s	Director	10e. Street and Number		,	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	h with		5810 Miriam Drive	2		21784			Unic	ed Sta	tes
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Decedent of	Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)		Race - Ameri Black, White,	
٥	after or ite	교	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2 ☑ No		1 8010 1110411, 010.7		ecify: • 11	oto.
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id ellygiene death after a standard of the markland a seent, the Mapical Examiner must be notified at event, the Mapical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						Wh	nite
ر ک	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. [Decedent's Usual Occu Give kind of work done	pation during most o	of working	16b. Kind	of Business/In	dustry
2	within 72 ene. than •nal	d m	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire					T 1
	e filed withi al Hygiene. I other than vent, Ice N		17. Father's Name (First, Middle, Last)		P_1	ant Techni		s Name (First, Middi			s Foliage
Maryland	ntal hed of	Be						te Smith	o, maileon (je.		
Ē	should be find Mental I marked of umatic eve	၉	John Edward Term		19h	Mailing Address (Stree			her City or To	wn State Zir	Codel
<u>S</u>	d2s than 7ie trau	1				10 Miriam				21784	. 6000
	es 1 and 2 should b of Heelth and Mente (Item 27 ie marked r other traumatic e	-	Daniel Hundertma: 20a. Method of Disposition			Disposition (Name of crematory or other pla		Date	1	on - City or To	own, State
<u></u>	Pages nent of int: If its iry or o		1 Burial 2 □ Cremation 3 □	Hemoval from State			_ ! 56	ept. 10,	0.1	• */ *3	3/70
altımore,	artme ortani njury		4 □ Donation 5 □ Other (Specify21. Signature of Fureral Service Licer		ake vi	ew Mem. Pa		2005	Sykes	ville,	NID.
Ba	permit. Pages Department of I Important: If Its any injury or or once.		Semu 6	aug		Burrier-O 1212 W. O	ueen Fu ld Libe	ineral Hom erty Road	ne & Cr Winfi	emator eld, M	y, P.A. D. 21734
			29 Part1. Enter the disease, or com shoc , or heart failure. List only	plications to t sed the one cause on each ine.	death. Do no	ot enter the mode of dy	ing, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
de	Pnysician	1	Immedi - Cause (Final disease or condition	YAN		ATIC	OA				Onser and Death
	/Medical		resulting in death)	Due to (or as a cor	sequence o	f):					
	Examiner		Sequentially list conditions,	b							
	sit sit	liner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence o	r):					
	and F-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a cor	seguence o	n.					
8760,	icate be executed physician and s the burial-transit					,-					
87	phys the	dical		_ d							
ox 6	eath certifii attending ; I for use as	/Me	IF FEMALE:	23c. If yes, outcome of pro-	egnancy				23d	Date of deliv-	arv
B	death certif e attending od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у			Month	Day Year
o.	at the de by the a tached	ysi	1 Yes 2 No 9 Unknown	9□ Unknown							
О.	The law requires that the tee by the bas been signed by the bage 2 should be detache	by Pt	Part II. Other significant conditions	ontributing to death but no	t resulting in	the underlying cause g	ven in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
Records,	uires n sign							1 🗆]Yes 2⊡N	o 3 ☐ Prot	pably 4 □Unknown
000	w requ	lete						24a. Wa		4b. Were auto	opsy findings available
æ	The law	Completed						per	opsy formed?	death?	mpletion of cause of
		0	25. Was case referred to medical	0.			26. Place o	of Death (Check only	2 No	1 🗌 Yes	2ENo
>	Physician: r this certifica ral director, p	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA	hor	sing Home 5 Re		Other (Special	(v)
ō			27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Ti	me of 28c. Inju		_	how injury or		,,
Division of Vital	nding f th. r: After e funer	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio		17 111]Yes 2 □N	0			
N N	or Attendate death Director:	HC	3 Suicide 6 Could not be determined		At home, far	m, street, factory, office			(Street and Nown, State)	umber or Run	al Route Number,
	s afte	Certification:	4 Nomicide	building, etc. (3)	Jecny)			011/01/1	own, orato)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			nysician: To the best of my niner: On the basis of exa							
	the hin 24 the F	Medical	one)	and manner stated.							
	To To	2	29b. Signature and title of certifler	WO MI		29c. Licen	ise number	78	29d. Date si	gned (Month,	Day, rear)
			- John LC	المالي المالي		リリ、		· · ·	ı	<u></u>	
	010 DNA	1	30. Name and ddress of person who	completed payse of death	(Item 23a) (Type, Print)	Laria	1. Lul	mp	2115	7
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's S	O//C Signature	CI WW	iryura		","		-
	ા Registi		SEP 1 3		w st	Corelis					
			JET 20			7					

				1 - State State Registrar	of Marylar		artment of tificate of	Health and Death		giene 0	05	31547
		Physici		1. Decedent's Name (First, Middle, Last) FAYE E.			ORTCH		2. Date of Dea Month SEPTEMB	th Day	Year	3. Time of Death
		/Medio Examir		4a. Facility Name (If not institution, give street and no	umber)	110		or Location of Deal			2005 ty of Death	3:20 PM
	***			CIVISTA MEDICAL CENTER				ATA, MARY			ARLES	
		Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ★ 1 □ M	7. Age (In yrs. 86	Yrs.	Months Day:		8. Date of Birth (Month, Day March I	4, 1919	9. Birth Cou Wes	place (State or Foreign ntry) t Virginia
		land w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. fnside City Limits
		deeth with the Maryland ms 23a or 28a-f ehow Finast ke notified at	ţō	Maryland Charles]	Hughesv	ville					1 ☐ Yes Ž No
		ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
		s 23s	era	13575 Valley Way	cedent Ever in U	10 12 1	Ma - Danidada -	20637			S A	
#	036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mentat Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-1 ehow any injury or other traumatic event, the Medical Examinat must be profiled at once.	by Funeral	Amed F	orces? 2121No live		was Decedent or f Yes, specify Cu 1 ☐ Yes 2 🛛 No	Hispanic Origin? (S Iban, Mexican, Puer Descrify:	specify Yes of No- to Rican, etc.)		ace - Ameri ack, White, ify:	
5	5-0	n 72 h	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ient's Usual Occi	upation e during most of wo	rking	16b. Kind of I	Business/fr	ndustry
R7	Maryland 21215-0036	d within giene. or then	Completed	Efementary/Secondary (0-12) College 12th	(1-4or 5+)	life. I	Clerk	red)		0:	ffice	
401	and	ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last) Charles S.	G	reen		18. Mother's Na Rosa	me (First, Middle,	Maiden Suma Helen	,	harpless
	aryl	should nd Me nmark nmark	^L	19a. Informant's Name/Relationship (Type, Print)			ng Address (Stree	et and Number or R				
11		and 2 selth a n 27 is		Leo J. Hortch/Spouse				Way, Hug				
>	Baltimore	ges 1 it of He If iten or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from	n State	cemetery, cren	sition (Name of natory or other pi			20c. Location	•	
T	Itim	artmen ortant: injury i.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	St.			own 9/26				Maryland
	Ba	Depa Impo eny it		Hors BAX	>			ress of Facility 1d-Echols 128, Cha			aryla	nd 20622
		Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Finaf disease or condition resulting in death)	each line.	th. Do not ent	er the mode of dy	ying, such as cardia	or respiratory arr	rest,		Approximate fnterval Between Onset and Death
		/Medical Examiner		Due to	o (or as a consec	quence of):	las.	Secret	ent			
		D tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consec			7,000				
	Ĵ,	cate be executed physicien and the burial-transit	Examiner	that initiated events c.	(or as a consec	quence of):						
	8760,	ate be hysicie the bur	dical	d								
	9	seath certific attending p	0	IF FEMALE: 23c, If yes, or	utcome of pregna	ancv				204.5	- A 4 - d - E	
	P.O. Box	The law requires that the death certifules has been signed by the attending tage 2 should be detached for use as	hysiclan/M	in the past 12 months?	birth 2 Feta	al death 3	Ectopic pregnan Other (specify)	су			ate of deliving	ery Day Year
		signed d be del	d by Phys	Part fl. Other significant conditions contributing to	death but not res	sulting in the u	nderlying cause g	jiven in Part I.	23e. Did to	- 4		he cause of death?
	COL	w requir s been si should	lete						24a. Was a	- 12		
	Vital Records,	The la ate ha page 2	Completed						autops perform 1 Yes	med? 2 No	prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
2	Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?					ath (Check only or			
A	ď	Attending Physiclan: r death. sctor: After this certific by the funeral director,	. To	27. Manner of Death 28a. Date	of fnjury	ER/Outpatien 28b. Time of	1 3LI DOM		dome 5 Reside			<i>(y)</i>
1	ion	ath. eth. or: Afte	ation	2 Accident investigation	nth, Day Year)	Injury	W	ork? ⊒Yes 2 ⊒No				
	Division	al or Atters after de l'Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At h ding, etc. (Special	ome, farm, str	eet, factory, office	Э	28f. Location (Si City or Town	treet and Num n, State)	ber or Rura	al Route Number,
		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Madical Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and mate and place	anner as s	stated. to the cause(s)
		vithii To th	Ž	29b. Signature and title of certifier	in M.	D	29c. Licer	nse number	2	9d. Date sign		
				1 4000				2289		7/.	22/	05
				30. Name and address of person who completed cau MATHUR, NALIN, MD 10 SA	INT PAT	RICKS I		ITE 404 W	ALDORF, 1	MARYLAN	ID 206	503
	3	Sta Registr		31. Date filed (Month Day Year) 2005	Registrar's Sign	ture	all of					

DHMH 17 Rev 1/2001

ORIGINAL

Amended It. 23b.per Phy. 09/14/2005 Carroll County, am. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per dr., 6848, 10/25/10 dhb Reg. Mer. Reg. No. U 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00a M Elwood Stanley Koerner, Jr 13 Sept 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3712 Watersville Road Mt. Airy Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Min. Yrs. 71 219-32-8807 June Director MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b Counts 10d. Inside City Limits rai', or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3712 Watersville Road 21771 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Motor and Air Freight Elementary/Secondary (0-12) other then College (1-4or 5+) Transportation Sales Carriers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elwood Stanley Koerner, Sr Louise Marie Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Koerner/wife 3712 Watersville Road Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/16/2005 Department of F Importent: if ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow Branch Cemetery Westminster, MD *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²² Pritts Funeral Home and Chapel, P.A. - K 412 Washington Road Westminster, MD 21157 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carcinoma Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certiticeta be executed physiclan and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2∏ No 1 Yes X No 1 Tyes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Certification; To After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide within 24 hours e To the Funerel D completely tilled i 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number ause of death (Item 23a) (Type, Print)
THE Patrickent Phrwy, Columbia 5 £ 30. Name and address of person who completed 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Van & Spelle Registrar SEP 1 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland Department of Feath and Mental Hygiene Reg. No. U () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 12_35 PM ERRY LAPOLE W /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATIMORE If Under 1 Year If Under 24 Hrs. University of MARYLAND Shock TRAVMA 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□F Days Months Hours Min. Yrs. 217/08/2440 **Director** 09 70 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23s or 28e-1 show the Medical Experimenmust be notified at 10d. Inside City Limits 1 Tyes 2 XNo Completed by Funeral Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17004 Sterling Road 21795 U.S.A.12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Carpenter Constuction 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other treumatic event <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) Be Edward W. Lapole ၉ Beverly A. Fouche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Lapole 17004 Sterling Road Williamsport, MD 21795 (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 2005 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory August 25, * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Jellice 12525 Bradbury Ave. Smithsburg, MD 21783 PAVIS MO1414 23a. Part - Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate nterval Between Onset and Death Immediate Cause (Final Physician D disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of): Examine sician and burial-transit The law requires that the death conflicate be executed Traumatic Brain Injury resulting in death) Last Due to (or as a consequence of): I'M APPROVED BY MEDICAL EXAMINES Box 68760 anding physician use as the buria Physician/Medical Motor CERTIFIC IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ŏ Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 DNo the Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 🗌 No patient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year 28c. Injury at Work? 28d. Describe how injury occurred After Motorcyclist in single vehicle 1 Natural 5 Pending 2 Accident 3 Suicide 06/26/2005 4:06a 1 ☐ Yes 2 XVo investigation M Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Boonsboro KD.

Rt. 67 & Locust Grove Kd. à 4 Homicide filled in I 24 hours a Roadway Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) medi 16533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMARE CUITAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 2 2005

ORIGINAL

3 Registrar's Signature

JOHN D. LEWIS JR. 05-06007 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla	nd / Depa	artment of H	lealth and I			05	31551
			Registrar 1. Decedent's Name (First, Middle)	e, Last)		timodic or i	Dealin	2. Date of Dea	Reg. No.		3. Time of Death
Н	Physici		John D. Le	wie Ir				Month	Day IBER 2,2	Year	5:55P. M
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	r Location of Death	I DELTER	4c. Count		J:JJP.
			PRINCE GEORGES	HOSPITAL		CHEVERLY			PRINC	E GEO	RGES
	Funeral		5. Social Security Number	1/ V M 2/7 E	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp	place (State or Foreign
-	Director		219-94-7439 Usual Residence of Decedent	2	26 Yrs.			Aug. 22	, 1979	Man	ryland
	wo.		10a. State 10b. County	10c. (City, Town or Lo	ocation				1	0d. Inside City Limits
	Mar	tor	Maryland Prin	ce George's		Lando	ver				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number	000150		10f. Zip Code	, 02		10g. Citizen of	What Cour	ntry?
	23a	raiC	1221 Na1	ley Road			20785		Uni	ted S	States
	er der Items	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 14. Rac Bla	ce - Americ ck, White,	ean Indian, etc.
36	4 within 72 hours after deeth with the Marylend liene. 1 then natural', or items 23a or 28s-f ehow tra Medical Examinat must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Give		1 ☐ Yes 2 🗓 No	Specity:		Specif	y: B.	lack
21215-0036	2 hou	ted		t's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/In	dustry
7	thin 7	Completed	(Specify only nighe Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	lite.	kind of work done of DO NOT use retired	during most of wor I)	king			
	filed wi Hygien ther th	Con	12th			La	bor			Priv	<i>r</i> ate
2	tal H d oth	Be	17. Father's Name (First, Middle,				18. Mother's Nan	, ,		,	
<u> </u>	12 should be filed v h and Mental Hygie 7 is marked other freumatic event, it	은	John D.		405 14 15				·lene Sc		
Maryland	es 1 and 2 should E of Health and Mant (Item 27 is marked r other treumatic e		19a. Informant's Name/Relations Alberta Hills			ng Address (Street a				_	Code)
ē,	s 1 end f Heelth item 27 other tr		20a. Method of Disposition		Place of Dispo	sition (Name of	1	Date	20c. Location	- City or To	own, State
Ē	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Qonation 5 ☐ Other (S			natory or other place Cremator	1	5/2005	C1ir	ton,	MD
galtimore,	permit. Pages: Depertment of h Important: If ite any injury or ot		21. Signature of Funeral Service			2. Name and Addres	-			•	
<u>n</u>	8268		1. 110hm 1.	Slewarx		4001 Een	ning Rd.	, N.E. W	lash., L	C 200	019
			23a. Part 1 Enter the disease, or sho 3, or heart failure. List	complications that caused the de- only one cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician	3 (Immediate Clause (Final disease or Education resulting in Seath)	_a multiple	auns	hot we	ounds				Onset and Death
	/Medical Examiner		resulting in Geath)	Due to (or as a conse							
		ē	Saquentially list conditions if any, leading to immediate	b. Due to (or as a conse	quence of):						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	S							
o Ĉ	en en rial-tr		resulting in death) Last	Due to (or as a conse	quence of):						
8/60	icate be executed physicien end the burial-transit	dical		d.						-	
ט	ertific ding p	Med	IF FEMALE:	220 If you systeems of promi					7	111	
ŏ	deeth certifii e ettending p d for use as	sian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 Live birth 2 Fe	al death 3	Ectopic pregnancy Other (specify)				te of delive onth	ry Day Year
<u>.</u>	y the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	30						
S,	requires that een signed b nould be deta	by P	Part II. Other significant condition	ons contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use conf	ribute to th	e cause of death?
cords	w require been sig should b							1 🗆 Y	es 2 No	3 ☐ Prob	abiy 4 ∐Unknown
Ď.	S S S	ompieted						24a. Was a		Were autop	osy findings available
	F ese	Соп						perfor	med? 2 No	death?	2 No
7118	Physicien: Th this certificete rai director, pag	Be	25. Was case referred to medica examiner?				26. Place of Dea	th Check only or	ne)	,	
5	Phys this al dir	5	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatier 28b. Time of		4 Nursing H	ome 5 Resid)
	After Ing	tion	1 Natural 5 Pendir 2 Accident Investig	(Month, Day Year)	Injury	Work	Yes 2 No	28d. Describe h	bject	Sho	†
DIVISION	Attar r dea ector by the	ifica	3 Suicide 6 □ Could	not be 28e. Place of Injury - At	home, farm, str			28f. Location (S	treet and Numb	er or Ryra	l Boute Number,
5	s effe	Certification;	4 Homicide	building, etc. (Spec	of re	siden	0	189161	State) Leon	ard	Reed
	To the Hospital or Attending Physicien: which 24 hours stier deals. To the Fungel Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2 X Medical	g Physician: To the best of my kr Examiner: On the basis of examir	nowledge, death	n occurred at the tim	ne, date and place,	and due to the o	cause(s) and ma	anner as st	ated.
	the the mplet	Med	29b. Signature and title of certifie	and manner stated.		29c. License		······			
	F.≱ F. 8		290. Signature and title of certifie	1 . Q	00 .				29d. Date signe		
	12		30 Name and address of pason	who completed state of death (Ite	m 23a) (Type,		.M.E.	S	EPTEMBE	к 3,2	.005
-	(3)		TATOLICIA AC	CNICA - POLLAR		111 PENN	STREET BA	ALTIMORE	, MARYLA	ND 21	201
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign					,		
	Registr	ar	SEP 1 5 21	105 Blow 16	Anse.						

		•	For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	irtment of tificate of	Health and f Death	Mental Hy	/giené (Reg. No.	005	31552	
	Dl		1. Decedent's Name (First, Middle	e, Last)					2. Date of D Month	eath Day	Year	3. Time of Death	
	Physicia /Medic	al .	Gertrude							ber 16			•
	Examin	er	4a. Facility Name (If not institution				_ ,.	, or Location of Dea			unty of Death		
- 1	ران سندست الران		St. Mary'		~	last hirthday)	Le d	onardtown ar If Under 24 Hr			t. Mar		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ■ F	7. Age (In yrs.	Yrs.	Months Day		n. (Month, D	ay, Year) • 1914	Cou	place (State or Foreign ntry)	
	Director	-	204-07-2812 Usual Residence of Decedent		91				Jan. I	, 1914	New	York	_
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	Mary -f sh	ō	Maryland St	. Mary's			Co1t	tons Poin	t			1 ☐ Yes 2 No	
	r 28a	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?	
	h with	D D	20277 Gerrard	Lane			2062	26		Unite	d Stat	es	
	deat	Funeral	11. Marital Status	12. Was De	ecedent Ever in U	.S. 13.	Was Decedent of	f Hispanic Origin? (uban, Mexican, Pue	(Specify Yes or Narto Rican, etc.)		Race - Ameri Btack, White	can tndian,	
٥	or Ite		1 Never Married 2 Mar	ned 1 ☐ Yes	2 🔯 No	1	1□Yes 2 @ N		,		ecify: Whi		
2	hin 72 hours after death with the Maryland 3. Medical Examener must be rediffed at	d by	3 ₩idowed 4 Divorced	Year or	Dates:								_
<u>7</u>	nation adjust	Completed	15. Deceder (Specify only highe	it's Education st grade completed	d)	(Give	tent's Usual Occ kind of work dor DO NOT use reti	ne during most of w	rorking	160. King (of Business/Ir	idustry	
2	within than	dm	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		chool Te	•		E.A.	ucatio	n	
N	be filed within 72 ital Hygiene. d other than "nai event, the Medic		17. Father's Name (First, Middle,			<u></u>	JIIOOT TE		ame (First, Middi			11	_
a	Mental arked o	o Be	Fred M. Basgi					Josep	hine Ker	n			
Maryland 21215-0036	should be and Menta marked umatic ev	ဥ	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stre	et and Number or F			wn, State, Zi	p Code)	_
	and 2 sealth ar n 27 is		Joseph J. Mill	er III/ (Grandson	P.O.	Box 555	Cuddeba	ckville.	New Y	ork 12	729	
Baltimore,		-1	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	olace)	Date		ion - City or T		_
Ê	Pages nent of int: If it iry or o		1 Burial 2 Cremation 1 Donation 5 Other (5		m State St	. Nich	olas Cen	netery 9-2	22-2005	Shave	rtown,	PA	
=======================================	permit. Pages 1 Department of H Important: If ite any injury or ott		21 Signature of Funeral Service	Licensee N		22	. Name and Add			-		ome, P.A.	_
m	90 E 8				Jr. M000			Lywood ke	oad, Leo	nardto		20650-0279)
	Physician /Medical Examiner	Examiner	23a. • • • • • • • • • • • • • • • • • • •	a	n each line.	isal Sta	or the mode of a	alle	ac or respiratory	arrest,		Approximate Interval Butween Onset and Cath	
D. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burtal-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	outcome of pregnale birth 2 Feta	ancy	Ectopic pregna			23d.	. Date of delive Month	rery Day Year	E.
P.0	that the de led by the a detached	Phy	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the	nderlying cause	given in Part I.	23e. Dio	tobacco use	contribute to	the cause of death?	
ds,	signed d be del			XAII			, ,		1]Yes 2□N	lo 3 Pro	bably 4 Unknown	
Š	v require been sig	etec	T	H	100				24a. Wa	san 2	4h Were aut	opsy findings available	
Vital Records,	The law te has age 2 s	Completed		VIIIVIII					aut per	opsy formed? 2 No	prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of	
ţ		a)	25. Was case referred to medica	al				26. Place of D	eath (Check only			3.0	
>	Physici this ce al direc	ToB	examiner? 1 ☐ Yes 2 ® No	Hospital:	☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA	Other: 4 Dursing	Home 5□Re	sidence 6	Other (Speci	ify)	
0	ng Ph ter th	ü.	27. Manner of Death 1 DNatural 5 Pendi	/A.4	te of tnjury onth, Day Year)	28b. Time o Injury	f 28c. Ir	njury at Vork?	28d. Describe	how injury of	ccurred		
0	Attending Physician: It death. ector: After this certification in the funeral director,	atle	2 Accident invest	igation				☐ Yes 2☐ No					
Division of	after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	min ad 200. Fie	ace of Intury - At hilding, etc. (Speci	ome, farm, st fy)	reet, factory, office	ce		(Street and N own, State)	umber or Rur	ral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in It	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	Examiner: On the	the best of my kno a basis of examina agner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in m	a time, date and pla ly opinion, death oc	ice, and due to the	e cause(s) and e, date and pla	d manner as	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certific	er /		111	29c. Lice	ense number	119	29d. Date si	igned (Month,	, Day, Year)	_
			· Ka	mart 1	arvas	=X4		2000	tl/	/-	16-6	र्	
			30. Name and address if person J. Patrick Ja		ause of death (Ite			Road, Ho	11vwood	Marv1	and 20	636	
	St	ate	31. Date filed (Month, Pay, Year				Land	1.044, 110					-
	Regist		V -	~ 1/		A 44	The same of the sa						

			1 - For State Registrar		State of		nd / Dep		nt of H	ealth a		ental Hy			31554
	Physici	an	Decedent's Name (First, Middle Florence	, Last) Eth	101	Moo	re					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution					4b City	Town or	Location of	Doath	09	12	2005 nty of Death	20:40 PM
	Examin	er	0	-	midi		Antil	40. City		1/15but				COMIC	
	Funeral Director		5. Social Security Number 222–16–7384	6. Sex			s. last birthday, Yrs.	If Unde Months	r 1 Year	If Under 2 Hours	4 Hrs.	8. Date of Bir <i>Month, Da</i> LO/28/1	th	9. Birth	nplace (State or Foreign untry) aware
	and		Usual Residence of Decedent 10a. State 10b. County			10c. C	City, Town or L	ocation							10d. Inside City Limits
	Maryi -f sho	tor	Maryland Wico	mico)	s	alisbur	÷у							1 ☐ Yes 2 🛣 No
	death with the Maryland ims 23a or 28a-f show	Director	10e. Street and Number					10f. Zi	p Code				10g. Citizen	of What Cou	untry?
	23a c	al D	32348 Mt. Herm	on E	Rđ				21804	<u> </u>			US	A	
30	172 hours after death with the Marylan "natural", or liams 23a or 28a-f show idical Executing transitive rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2√2 Marr 3 □ Widowed 4 □ Divorced		 Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da 	ces? 2 1 No	U.S. 13.	Was Dece If Yes, spe 1 \(\text{Yes} \)		spanic Orig n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No lican, etc.)		Race - Amer Black, White cify: W	
3	tural	ed t	15. Deceden	's Educa			16a. Dece	dent's Usu	ial Occupa	ation			16b. Kind o	f Business/li	ndustry
9500-61212	filed within 72 Hygiene. Ather then "nat ont, the Medica	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade	Completed) College (1-	-4or 5+)	life.	make:	ise retired,	furing most)	o <i>f worki</i> n	g	Dome		,
Maryland	should be file and Mental Hy, marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Lewis Albert Ha	,	ngs							(First, Middle, anche	Maiden Sun	ame)	
	Tra Tra		19a. Informant's Name/Relations Barbara Moore I			ter						Route Number Salisb			
Baitimore,	Pages 1 and ment of Healt lant: If item 2 lury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		moval from S		Place of Dispo cemetery, cre LCOM1CO	matory or Memo	other place	9)	9/16	ate 5/05	20c. Location	on - City or T bury,	
Bait	permit. Page Department important: If any injury or once.		21. Signature of Funeral Service	icen	nne	- Cf	Park	HOIIC	nd Addres Way Snow	Funera Hill	al Ho	ome Pro Salisk	ofessio	nal A D 218	ssociation 04
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complic only one	ations that cause on ea	used the deach line.	ath. Do not en		de of dying		ardiac or				Approximate Interval Between Onset and Death
9	/Medical Examiner		resulting in death)	(a.	Due to (c	or as a conse				apre co					
/60,	ate be executed tysicien and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.		or as a conse									
	icate b physic s the b	dicai		d.	_										
O. Box 68	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23		rth 2 ☐ Fe ant at time of	tal death 3[⊒Ectopic p ⊒ Other (s					1	Date of delive	very Day Year
<u> </u>	as tha		Part II. Other significant condition	ns cont	ributing to de	ath but not re	esulting in the t	underlying	cause give	en in Part I.			obacco use c		the cause of death?
Vital Records,	a law require has been si e 2 should b	Completed								-		24a. Was	an 24	b. Were aut	opsy findings available ompletion of cause of
<u></u>						_						1 ☐ Yes	rmed? 2 ⊟ No	death?	2 No
\begin{array}{c}	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Ho	spital:		7500		OA Othe			Check only o			
on of	ing After uner	-	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		28a. Date o		28b. Time of Injury		28c. Injury Work	4 🗀 Nur	2	e 5 Resided Re			(fy)
Division	ii or Attendi after death. i Director: A d in by the fi	Certification:	3 Suicide 6 Could a 4 Homicide determ		28e. Place buildin	of Injury - At ig, etc. (Spec	home, farm, st	reet, factor	y, office		2	8f. Location (: City or Tox		mber or Rui	al Route Number,
	the Hospitai or nin 24 hours afte the Funerai Dir npletely filled in	Medical C	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physi Examin	cian: To the er: On the ba and mann	isis of examin	nowledge, deal nation and/or in	th occurred ivestigation	d at the tim	e, date and pinion, death	place, a	nd due to the d at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tile of certifue	1					ic. License	number	8		29d. Date sig	ned (Month)	Day, Year)
	19		30. Name and address of person	rul	St. C			Print)				Par / Visi			
	Sta Registi		31. Date filed (Month SE/Deg)	5 20	05 ^{32. B}	gistrar's Sign		Low	-				(

DHMH 17 Rev 1/2001

4882-91-88E

Florence E. Moore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:14 AM September 10 2005 MARIE MELICHAR MCTVER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Laurel 15409 Bauer Lane 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 🖾 F 52 Sept.15, 1952 Pennsylvania 192.44.9700 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show treumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Prince George's Maryland Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15409 Bauer Lane 20707 U.S.A. items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a any injuy or other treumatic event, the Medical Experiment and purpe. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Flementary/Secondary (0-12) 2 Years Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rudolph Melichar Margaret J. Kaehler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15409 Bauer Lane, Laurel, Maryland 20747 Donald Michael McIver/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 9/14/2005 Brentwood, Maryland 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service License 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 Years Physician Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Bone Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Liver Metastasis Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐ Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 ☐ Yes 2 X No certificate Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 XNo 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12005 145014 SEPTENBEL 12 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabella Martire, MD, 8343 Cherry Lane, Laurel, Maryland 20707 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 14 2005 Registrar

		1	For State Registrar	State of Marylan		artment of h <i>rtificate of</i>			ene 005	31556
ý	Physicia	an	Decedent's Name (First, Middle, Last JOSHUA FARREL)					2. Date of Death Month SEPTEMBE	Day Year	3. Time of Death 1:00 A M
	/Medic Examin Funeral	er _	HOLY CROSS HOSPIT. 5. Social Security Number 6. Security Number	street and number)		4b. City, Town, of SILVER If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 09/07/20	Year) Co	th
(P.	Director		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		09/0//20	US MAR	10d. Inside City Limits 1 X Yes 2 □ No
	death with the Maryland me 23a or 28a-f ahow	al Director	MARYLAND PRINCE G 10e. Street and Number 12828 GLYNIS ROAD	EORGE'S CLIN	ITON	10f. Zip Code 20735	j		Og. Citizen of What Co	puntry?
_	I within 72 hours after death with the Marylan liene. Ithin." natural, or Iteme 23a or 28a-f ahow the Marital Erantine must be motified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of life Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:		14. Race - Ame Black, Whit Specify: BL	te, etc.
0500-6121	within 72 hou ene. than "natura he Madical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of worked)	king	16b. Kind of Business	/Industry
Maryland 2	al Hyg al Hyg fothe ivent,	To Be Co	17. Father's Name (First, Middle, Last) PATRICK A.	MITCHELL			DAWN	e (First, Middle, M	Maiden Surname) FARRELL	
മ്	1 and 2 Health a am 27 lu	771	19a. Informant's Name/Relationship (7 PATRICK A. MITCHE 20a. Method of Disposition 1 □ Burial 2 ※Cremation 3 □ 4 □ Donation 5 □ Other (Specify	LL/FATHER 20b. F	12828 Place of Dispo emetery, cre	B GLYNIS osition (Name of matory or other pla	RD., CLIN	TON, MAR	City or Town, State, 2 YLAND 2073 20c. Location - City or BRENTWOOD.	Town, State
Baltın	permit. Pages Department of Important: If its any injury or of		21. Signature of Funeral Service Licen 23. Part 1. Enter the disease, or comp	Ludewig	1 I	2. Name and Addr 1800 NEW	ess of Facility HIN HAMPSHIRE	ES-RINAL AVE., S	DI FUNERAL ILVER SPRI	HOME, INC.
Sale of the sale o	Physician /Medical Examiner	liner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. PULMONARY HY Due to (or as a conseq b. SEVERE OLIGO Due to (or as a conseq	TPOPLAS uence of): DHYDRAN uence of):	SIA MNIOS				Interval Between Onset and Death
8760,	icate be executed physicien and s the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c. OBSTRUCTIVE Due to (or as a consect d. RENAL DYSPLA	juence of):	LHY				
O. Box 6	Physicien: The law requires that the death certifics this certificate has been signed by the attending ptrail director, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Fett 4 Pregnant at time of continuous 1 Unknown	Ideath 3	⊒Ectopic pregnan ⊒ Other (specify)			23d. Date of de Month	blivery Day Year
rds, P.O	w requires that I been signed by should be deta	b	Part II. Other significant conditions of BILATERAL PNEUMOT		sulting in the	underlying cause g	iven in Part I.		pacco use contribute to es 2 X No 3 ☐ P	to the cause of death? Probably 4 □Unknown
al Reco	Physicien: The law n this certificate has be al director, page 2 sh	Completed	PNEUMOMEDIASTINUM				00 Pi 4 Pi	24a. Was a autops perform	ned? death? 2 A No 1 ☐ Yes	autopsy findings available completion of cause of s 2 \(\text{No} \)
Division of Vital Records,	ling Afte	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not b determined	e 28e. Place of Injury - At h	28b. Time Injury	of 28c. Inj W 1[then 4 Nursing H ury at ork? Yes 2 No	28d. Describe ho	ence 6 Other (Special Control of Special Control of	
ā	spitel or nours afte nerel Dir / filled in	edical Cert	29a Certifier 1X Certifying Ph	building, etc. (Speci sysicien: To the best of my kn niner: On the basis of examin	owledge, dea	th occurred at the	time, date and place	, and due to the ca	ause(s) and manner a	is stated. le to the cause(s)
	To the Ho within 24 t To the Fu	Med	29b. Signature(ând title of certifier	and manner stated.	leiu	29c. Lice	nse number		9d. Date signed (Mon	
			30. Name and address of person o MARY LENORE KESZL 31. Date filed (Month, Day, Year)	ER, M.D., 1500	FORE	o, Print) ST GLEN F		R SPRING		
	St Regist	ate rar		32/Registrar's Sign	K A	ale				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Vaar **Physician** Helen M. Mukes Sept. 11 2005 17:10 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2₽F 439-20-4684 85 Director May 12, 1920 LA Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Calvert MD Solomons 10e. Street and Number 10f Zip Code 10c. Citizen of What Country? 13325 Dowell Road 20688 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If item 27 Is marked other that any injury or other traumatic event, Inst. 2006. Self-Employed 8 Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown Louise Lane 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Washington - Daug. in law 1444 Gregg Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Resurrection Cem. 9-17-05 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bell Funeral Home, P. 6503 Old Branch Ave. Temple Hills, MD 20748 1. Enter the disease, or o mp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** iars disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) □Yes 2 No detached the 9☐Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2∏ No 1 Yes 2 ₹No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Tes 2 No death. 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and life of certifier 63 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11845 H. G. Trueman Road, Lusby, MD 20657 Sylvia Batong, M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. 2.005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MARGARET JUNE MEADOR September 11, 6:00 pM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Months 76 Director 579-32-4884 June 7, 1929 Washington, DC Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f ahow itam 27 is marked other than "natural", or itame 23e or 28e-f abov other traumatic evant. The Modical Examinar must be notified at 1 X Yes 2 ☐ No Director Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1457 Chatham Court 21114 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2MNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) 8 Sales Associate K-Mart 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Powers Lois Edith Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If Itam 27 is eny injury or other trai once. Carolyn Wilson - Daughter 1757 Arrowood Drive, Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/15/2005 Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service House 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Physician artery mony 413 /Medical Hypertensum Examiner equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit law requires that the death certificate be executed Diaketer Due to (or as a consequence of the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 25 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA 9-12-05 40519 Name and address of person who completed cause of death (Item 23a) (Type, Print) PARIC, Welen Burnie MIRZA . Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend ItemsState of Maryland / Department of Health and Mental Hygiene 23a, Pt1, Pt11, 25, 21, 28a-fperMF6847, 09/28/05dhb Certificate of Death Reg. No LU 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 327 AM FREDERICK THOMAS O'DONNELL AUGUST 16 2005 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER **CHEVERLY** PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) Months Days 1 M 2 □ F Hours 212-40-2570 66 MD Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, Stete 10b. County 1 ☐ Yes 2 X No QUEEN ANNE'S **GRASONVILLE** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 111 CHESTERWYE LANE USA 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) O. WOODROW O'DONNELL MARIE ANNA LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) MIRIAM KASPER/SISTER 807 BUCKINGHAM DRIVE, STEVENSVILLE, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State AUG. 17, 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD CENTER, LLC. 2005 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 106 SHAMROCK ROAD, CHESTER, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Compromised Respiration Immediate Ceuse (Final AMBIONA disease or condition resulting in death) Due to (or as a consequence of) 0% CERTIFICATION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Idb. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Obesity, Seizure disorder, Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Ventslower Sunnen 1 L Vas 2 L No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 XYes 2500 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth

Physician /Medical Examiner

physician and the burial-transit

USB BS 1 attending for use as

page 2 should be

this funeral

rector: /

after

within 24 hours after To the Funeral Dire completely filled in b Hospital or

ŧ

Examine

Completed by Physician/Medical

Be

P

Certification:

edical

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f showner must be notivised at

ò

al Hygiene.

and Mental I

f Health

filed within 72 hours after

Maryland 21215-0020

altimore.

Box 68760.

P.O.

Records,

Division of Vital

Directo

Funerai

2

Completed

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

5 Pending investigation 1 Naturel Z. Acciden

6 Could not be determined

28e. Date of Injury (Month, Day Year) 08/16/2005

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing home

28b. Time of Found 3.10a

28c. Injury at Work?

1 ☐ Yes X No

28d. Describe how injury occurred Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, Stat Cladys Spellman N.H. 2900 Mercy In., Hyattsville

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

| Mile | March | Mile 29b. Signature end title of certifier

3 ☐ Suicide

29a. Certifier

4 I Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EMD 4203 Queensbury Rd Hyattsville MD 20781 A.

State Registrar

31. Date filed (Month, Day, Year) SEP 2 8 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Adron Uriah O'Neal, Sr. September 11:08 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 22, 1933 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 72 Yrs. June Wash., DC Director 578-44-0645 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23s or 28e-f show the Medical Examiner rust be notified at 1√2 Yes 2 No Director Maryland Prince George's Laure1 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20708 United States 14030 Briarwood Dr. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Graphic Illustrator Government other 17. Father's Name (First, Middle, Last) Be 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 le marked ott jury or other traumatic even Uriah O'Neal Nora Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi C. O'Neal - Wife 14030 Briarwood Dr., Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Maryland Veterans Cem. 9/20/05 Cheltenham, MD * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) Physician 7-1-2005 Gangrene Left Foot /Medical Due to (or as a consequence of) **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Chronic Renal Failure and Due to (or as a consequence of) Box 68760, physician Completed by Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy performed? certificate 1 XYes 2 No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo13668 9-12-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Azher Hussain, M.D. 4917 Edge Wood Rd., College Park, MD 31. Date filed (Month, Day, Year) 329 Registrar's Signature State Registrar SEP 1 5 2005

		-	For State Registrar	State of Ma	arylan		artment of H		and Me	, ,	giene leg. No2 (105	31561
			Decedent's Name (First, Middle, Last)			-			2	2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		RALPH EUGI	=NE "	PEI	DIC	ori		3	Septem.	ser 13	2005	6:53PM
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or				4c. Cour	nty of Death	
			Caroll Hosp) fer	not hirthday	If Under 1 Year	If Under:	-	3. Date of Birth		CSLLO	
	Funeral Director		5. Social Security Number 6. Sec. 220–28–8983	M 2□F	75	ast birthday) Yrs.	Months Days	Hours	Min.	(Month, Da)	(, Year)	Coun	lace (State or Foreign try) 1land
			Usual Residence of Decedent							our 5,	1550		
	ahow a show	_	10a. State 10b. County		10c. City	, Town or Lo	ocation	Mostr	minst	er		11	0d. Inside City Limits
	Ba-f s	Director	Maryland Carr	coll			14471.0.1	, ico a			10g. Citizen o	(1475-1-0	1 ☐ Yes 2√ No
	a or	ā	10e. Street and Number 1539 Old Manches	ter Road			10f. Zip Code	2115	57		US US		uy r
	ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba			ify Yes or No-		ace - Americ	
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "netural", or items 23a or 28a-f show event, the Medical Evanting must be notified at	by Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 反↑ If Yes, Give	No		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	in, Mexican Specify:	i, Puerto Ri	ican, etc.)	Spec	lack, White, cify:	etc. hite
Ö	hours tural		3 Widowed 4 Divorced	Year or Dates:		16a Dece	dent's Usual Occupa	ation			16b Kind of	Business/Inc	
7	in 72 n "ne n "ne	plete	(Specify only highest grad	e completed)		(Give	kind of work done of DO NOT use retired	durina mosi	t of working	7			
212	d within giene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	0+)	7	Truck Driv	ver			T:	ruckin 	g Company
Maryland 21215-0036	be filed ital Hygie of other event, I	Be	17. Father's Name (First, Middle, Last)	cond Con						First, Middle,		ame)	
<u>Y</u> a	should be and Mental marked o	은	Charles W. Pedd:		•					s Selw			
Mar			19a. Informant's Name/Relationship (T) Dorothy Peddicord				ng Address (Street a						
	is 1 and 2 of Health a item 27 le		20a. Method of Disposition	A, WIIC	20b. P	lace of Dispo	sition (Name of		Da Da			n - City or To	
ē	00		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)				natory or other plac Cemetery		09/17	/2005	Hamr	ostead	. MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		723		2. Name and Addres			Eline H		•	,
m	Deg Cura		Steven (192/11	ne		934 South	n Mair					74
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused ne cause on each lir	d the death ne.	n. Do not en	er the mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			Sepsi.	2					10 43\Z
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):							
	is in	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):							
	outed id ansit	Examlne	cause. Enter Underlying Cause (Disease or injury) that initiated events	c.									
ó,	sate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequ	uence of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d									
9	eath certific attending p	Physiclan/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incv					23d [Date of delive	ID.
Вох	atten d for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	Ideath 3	□Ectopic pregnancy □ Other <i>(specify)</i>	'					Day Year
0	t the de by the tached	hysi	9 Unknown	9□ Unknown									
s, D	The law requires that the tie has been signed by thogge 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death b	ut not resi	ulting in the u	inderlying cause give	en in Part I.					ne cause of death?
ord	w require been si should b									1 🗆 Y	es 2 No	3 Prob	ably 4 □Unknown
Records,	law r las be	Completed								24a. Was autop	sy	prior to cor	psy findings available apletion of cause of
E H		Sol									med? 2 No	death? 1 🗌 Yes	2 🗆 No
of Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0.00		(Check only of			
	Phys r this sral dii	To :	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatie 28b. Time of	f 28c. Injun	yat		e 5 Resid			/)
ion	Attending I ar death. ector: After by the funer	atlor	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	M 1 🗆	k? Yes 2⊡	No				
Division	l or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide de mined	28e. Place of Inj building, et	ury - At ho	ome, farm, st	reet, factory, office		28	3f. Location (S City or Tow	Street and Nui m, State)	nber or Rura	l Route Number,
	urs af urs af arel D			<u> </u>									
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	edical		rsician: To the best iner: On the basis o and manner st	f examina								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	W.10.	- /	7	29c. Licens				29d. Date sig	ned (Month,	Day, Year)
) ,	/			Mrs Chi	ell,	20	1000	3994	3		Sept	moer	14,2005
×	02/0		30. Name and address of person who c		death (Item	23a) (Type,		4 103	h - \n -	10 -		2452	
)	-2-	10	31. Date filed (Month, Day, Year)	20 5	ar's Signa	turk 3	houles	ves.	S. 12 inst	TYIN		011)/	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 15 2	005	ar's Signa	10 1							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 8,9 per FH, C848, 10/25/05dbb Reg. No. 31562 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9M/mgh/05 **Physician** Francis Vernon Perry 10:40 p.m /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 3502 Blue Ball Road, Elkton, MD Elkton Cecil If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days Hours Yrs Director 184-20-5160 78 12/09/1921 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other then "naturel", or items 23e or 28e-f sho treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 USA 3502 Blue Ball Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? ↓{\dagger}\text{Yes} 2 □ No 1\dagger Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ₩ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DuPont Assistant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fin and Mental H Vernon F. Perry Anna Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is and 2 st if Health ar iftem 27 is or other tr 3502 Blue Ball Rd. Elkton, MD 21921 Ann Perry (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If iten
eny injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Memorial Park 9/15/05 New Castle, DE 22. Name and Address of Facility McCrery Funeral Homes, Inc. 21. Signature of Fundal/Service Licer 1400788 3924 Concord Pike, Wilm., DE 19803 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine physesun requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) use ŏ ed by the a detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tea 2 No þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed ate has t 1 Yes 2 No certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending investigation s after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai or To the Hospital or within 24 hours aft To the Funerel Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 02000 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas Biasotto, DO 620 Christiana Rd., Newark, DE 19713

Registra

State

			State of Maryland / Dep 1 - State Registra MEND#31&32, see#32, 9/14/05, BW, McCo Ce	artment of Health and Mental	2000	0150
			1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No.	3. Tithe of Death
	Physicia		John Francis Quinn, Sr.	Month	Day Year ember 12, 200	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
		•	3503 DePauw Place	College Park	Prince G	George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8. Date c Months Days Hours Min. (Month	of Birth 9. B	irthplace (State or Foreign Country)
	Director		209-22-3990 tx□M 2□F 75 Yrs.		17, 1930 Per	* *
	and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	darylan f ehow	ō	Maryland Prince George's Coll	ege Park		P☐Yes 2☐No
	the t	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What (Country?
	3a or		3503 DePauw Place	20740	USA	
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes of	or No- 14. Race - Arr	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ehow important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ehow and injury openiar traumatic evant, the Medical Examinar must be notified at ance.	by Fur	Armed Forces? 1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give Year or Dates: 1948-52	If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 ☐ Yes 2 ☐ No Specify:		white
9	2 ho	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Busines	s/Industry
215	hin 7 9.	ple	(Specify only highest grade completed) (Given infe.) Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)		
	ad with	0		f Engineer	Hospita	L
nd	al Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	ddle, Maiden Sumame)	
yla	Meni Meni arke	P	Frank A. Quinn	Mary A. McG		
Maryland	2 sh and is m			ing Address (Street and Number or Rural Route N		
	1 and Health am 27 Mar t		Marjorie G. Quinn/ Wife 3503 20a. Method of Disposition 20b. Place of Disp	DePauw Place, College osition (Name of Date	Park, MD 207	
סר	nt of F		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place) September		i Town, State
Baltimore,	artmentant			's Cemetery 2005	_Hanover To	wnship, PA
Ba	permii Depar Impor any ir			2. Name and Address of Facility rancis J. Collins Fune: 00 University Blvd, W,		ng, MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each fine.	iter the mode of dying, such as cardiac or respirate	ory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery D	isease		4 Years
	/Medical Examiner	11	Due to (or as a consequence of):			
п		0	Sequentially list conditions, if any, leading to immediate cause Enter Industrying b. Atrial Fibrillati Due to (or as a consequence of):	on		4 Years
	uted I Insit	Examiner	Cause (Disease or injury			
Ć,	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			-
8760,	cate be exphysician at the burial	dical	d			
9	tifica ng ph as th	Medi	T			
Вох	death certificate be executed e attending physician and of for use as the burial-transii	an/h	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetaf death 3	□Ectopic pregnancy	23d. Date of d	
O. E	ie dea the at hed fo	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)	Month	Day Year
P.	ac of	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underhing eques gross in Port I	Did tobacco use contribute	to the sauce of death?
JS,	uires that signed to d be det	by	Lung Cancer	. •		Probably 4 Unknown
Oro	w requ been shouk	etec				
Records,	e lav has	Completed by			Was an 24b. Were a 24b prior to 24c death?	autopsy findings available completion of cause of
a		e Co	25. Was case referred to medical	1 T Y		s 2 No
Vital	Physician: this certific al director,	00	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check of D		
of		To It	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at 28d. Descri	ribe how injury occurred	өспу)
ion	tanding Physician: leath. tor: After this certific the funeral director,	ation	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	l or Attandi after death. Director: A I in by the fu	iffica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office 28f. Locati	on (Street and Number or F r Town, State)	Rural Route Number,
D	tal or A	Certification:	Ballang, etc. (opeciny)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner-stated.			
	To the To the comp	×	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)
1	oxl		* X //orde W/	D25430	Septembe	r 13. 2005
,	0 ` `		30. Name and address of person who completed cause of death (Item 23a) (Type John Margo Lis, M.D. 13952 Baltimore	Print) a Avenue, Laurel, MD 20		
	, Sta		31. Date filed (Month, Day Year) 32. Registrats Sygnature	- Lu J GED 1 4 2005	l 1	Angelie 3
DH	Registi MH 17 Rev 1/2	-	1/00/1/00	SEP 14 2005	brown 15	Japan -

For State Registra
1. Decedent's
MARIA

State of Maryland / Department of Health and Mental Hygiene

	20	13	goman
Reg. No	(U	Ш	-
		_	~

Physician	
/Medical	
Examiner	

Funeral

Director with the Maryland

or 28e-f show Examiner must be notified at Items 23e e filed within 72 hours after of Hygiene.
I Hygiene.
other then "natural; or iter Pages 1 and 2 should be nent of Health and Mental I soft: If item 27 is marked o

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> as the burial-transit attending physician signed by the a this After

Division of Vital Records, P.O. Box 68760.

The law requires that the death certificate be executed or Attending Physicien: s after dec. filled in within 24 hours a To the Funerel C

Certificate of Death Name (First, Middle, Last) 2. Date of Death SEPTEMBER Day 4, 2005 A CHRISTINA RICHARDSON 5:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WESTMINSTER CARROLL 3555 CEMETERY LANE Social Security Number Birthplace (State or Foreign MARYLAND 7. Age (In yrs. last birthday) 1 □ M 2 XX 219-44-9646 1946 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits CARROLL WESTMINSTER MARYLAND 1 Yes 2000 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 UNITED STATES 3555 CEMETERY LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2\times No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ve kind of work done during most of working

. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM JOSEPH DOUGHERTY, SR. IDA FRANCIS BURKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILSON L. RICHARDSON SR/HUSBAND 3555 CEMETERY LANE, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. EVERGREEN MEM GARDENS 9/16/05 FINKSBURG, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME 21157 91 WILLIS STREET, WESTMINSTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 □Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 -No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 🚛 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one the of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and Waster

State Registrar 31. Date filed (Month, Day,

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of New Hospital or Attending Physical P

	1 For State	State of Mar		artment of H				giene Rog. N			
	Registrar 1. Decedent's Name (First, Middle, Last)			inouto or i	Joann		2. Date of De		UUJ	3. Time of	Dath
n	Freddie A	A. Robinson	1				Septemb	per .			P M
al er	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of		-		County of D		
	6300 Walton Avenue	<u> </u>		Suitla				P		George	
	5. Social Security Number 6. Sex 1577–46–7366	7. Age (i M 2□F	n yrs. last birthday) 70 Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 7.	y, Year)		Birthplace (State of Country) shington	
	Usual Residence of Decedent					<u>'</u>	July /	17.)) wa	SHIHECOH	, вс.
_	10a. State 10b. County		Oc. City, Town or Lo							10d. Inside Ci	
ecto	Maryland Prince Go	eorge	Suitland							1x Yes	- INO
	6300 Walton Avenu	ıe		10f, Zip Code	2074	6		10g. Citizen of What Country? United States			
Completed by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 🕱 Divorced	12. Was Decedent Eve Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	1907	Was Decedent of H If Yes, specify Cuba	ispanic Ori n, Mexican Specify:	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, W Specify:		
leted	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	lurina mos	t of worki	ng	16b. Ki	nd of Busine	ss/Industry	
dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 2		rresponde	,	Ana 1	vst	F.	ederal	Governm	ent
0	17. Father's Name (First, Middle, Last)			LICOPONGO			(First, Middle,			OOVELIM	- III
0	Douglas Robinson	n .			۷e	rlie	Bulloc	2k			
	19a. Informant's Name/Relationship (Ty) Carrie M. Elliott			ng Address (Street a						e, Zip Code) 20774	
	20a. Method of Disposition	-	20b. Place of Dispo	sition (Name of	- 1		ate		_	or Town, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Fort Line	natory or other plac	1	Sent.	15. 20	05	Brentw	rood. MD.	
	21. Signature of Funeral Service License	111	_	Name and Address		y Po	pe Fune	eral	Homes	oou, iib.	
	INTO TOX	Tehler				55 Fo	38 Mar] restvi]	bord le.	Pike	20747	
	23a. Part1. Enter the disease, or comflishock, or heart falls 6. List only on Immediate Cause (Final disease or condition resulting in death)		e death. Do not ent		g, such as					Approximate Interval Bette Onset and I	ween
	(Southing in doubl)	Due to (or as a c									
er	Sequentially list conditions, b	Dualto (or as a o	onsecuente off-								
Examine	cause. Enter Underlying Cause (Disease or injury that initiated events										
Exa	resulting in death) Last	Due to (or as a c	onsequence of):								
dical		1									
Φ.	IF FEMALE:									The state of the s	
Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				2	23d. Date of d Month		′ear
H.	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	nderlying cause give	en in Part I.		23e. Did to	obacco u	se contribute	to the cause of d	eath?
d b	Diabetes Mellitus			, ,			1 🗆 ነ	/es 2[_No 3 _	Probably 4	Inknown
ete	Hypertension						24a. Was	an	24h Were	autopsy findings	available
щ	- iij perconszon						auton		prior t death	o completion of ca ?	tuse of
ø	25. Was case referred to medical				26 Place	of Death	1 ☐ Yes (Check only o		1 LIY	es 2 No	
0 8	examiner? 1 Yes 2 XNo	lospital:	2 ER/Outpatien	t 3 DOA Othe		-	ne 5 X Resid	-	3 □Other (Si	pecify)	
	27. Manner of Death 1X∑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Injury Work	at t? Yes 2 □ I	2	8d. Describe h	now injury	y occurred	,,	
rtifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)				28f. Location (S City or Tox			Rural Route Num	ber,
edical Certification;	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of ner: On the basis of example and manner stated	amination and/or inv	n occurred at the tim	e, date and	d place, a	and due to the o	cause(s) date and	and manner place, and d	as stated. ue to the cause(s	
Mec	29b. Signature and title of certifier	and mainer states		29c. License	number			29d. Date	e signed (Mo	nth, Day, Year)	
	1 CAGA M	D		D0061	665	Ma	ryland			14, 200	5
	30. Name and address of person who co				va 00	4.22					
	John A. Dooley, M. 31. Date filed (Month, Day, Year)	D. 50 Irvi		, wash, l	JC 202	+ 4 4					
:	on Date med (morning Day, rear)	or agistial s	and and a marine								

SEP 1 5 2005

			1 - For State Registrar	State of Ma		d / Depa	artment o	of He	alth ar	nd Me	ntal Hygi	iene	005	31566
	Physici	an	Decedent's Name (First, Middle, Last,								Date of Death Month Septemb		1.4 Year	3. Time of Death 005 6:05 PM
	/Medic	al	Dorothy Carol 4a. Facility Name (If not institution, give		ottm	an	4b. City, To	wn orl	ocation of I		Septem	_	ounty of De	
	Examin	er	Harford Memori		al				Grac				Harfor	
	Funeral Director		217-10-3070	x 7. Age ☐M 21☑F 8		last birthday) Yrs.	tf Under 1 \ Months D	Year Days	tf Under 24 Hours	Min. 8.	Date of Birth Month Bay 6/192	Year)	9. B Mai	inhplace (State or Foreign Sourcy) Tyland
	land ow		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Mary m-f sh	to	MD Harfor	d		Aber	deen							X□Yes 2 □ No
	ith the	Director	10e. Street and Number				10f. Zip Co				10	_	on of What C	Country?
	s 23a	rali	732 Webb Stree		Constant	6 12		2100		-2/6		U.S		erican Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be mailised at QDCs.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Vidowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2554 tf Yes, Give Year or Dates:			Was Deceden tf Yes, specify 1 ☐ Yes 2 ☐		Mexican, F	Puerto Ric	ean, etc.)		Black, Wh	ite, etc.
ဝို	72 hor	eted	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usual C	occupati	on ring most o	of working	1	16b. Kind	of Busines	s/Industry
2	ithin 78.	Completed by	Elementary/Secondary (0-12)	Cotlege (1-4or 5	i+)	Homem	kind of work of DO NOT use i	retired)	raig most o	. Noming		Tn	Home	
7	Hygier Hygier Ther ti	CO	12 17. Father's Name (First, Middle, Last)			HORIE	arcı	1	8. Mother's	s Name (F	First, Middle, N			
and	d be f	To Be	Carl Brown								hline		umamoj	
Maryland 21215-0036	nd 2 shoul lith and Me 27 is meri r traumati	-	19a. Informant's Name/Relationship (7) Mark Schlottma				ng Address (S				Route Number, erdeen			
re,	of Hea		20a. Method of Disposition		20b. P	Place of Dispo emetery, crei	osition (Name matory or othe	of or place)	h /1	Date		-		r Town, State
<u>E</u>	Page ment e		1 ∑Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		St.	Paul'	s Luth	erar	ı cemi.	•	, ,	aber	deen,	MID.
Baltimore,	permit. Departr Import any inj		21. Signature of Funeral Service Licens	milke	Les.	M1 22	2. Name and A Tarri: Aberd	Nddress ng-C een	of Facility argo Mars	Fune	eral Hor	1-33	P.A. 99	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of timmediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lir a. <u>Birlos</u> Due to (or as	fera	2	Prec			ardiac or r	espiratory arre	st,		Approximate Interval Between Onset and Death
68760,	ate be executed hysician and the burial-transit	Ical Examiner	d.											
.O. Box 6	the attending p	Physiclan/Med									23	23d. Date of delivery Month Day Year		
<u>α</u>	ires that the signed by dipe detac	by	Part II. Other significant conditions co	ntributing to death be							23e. Did tob		,	to the cause of death?
Sor	w requir been si should	etec	To Take	2						_	24a. Was an			autopsy findings available
Vital Records,	ysicien: The lav is certificate has director, page 2	Completed	Jen en en en	~							autopsy perform 1 Yes 2	ed? No	prior to death? 1 \(\sum \text{Ye}	completion of cause of
₹	ysicie is certi directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 211/	ER/Outpatier	nt 3 DOA	Other:			Check only one 5 ☐ Reside		Other (So	ocihi)
Division of	fune fune	atlon: To	27. Manner Death 1 Maturat 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Da)	ry	28b. Time o tnjury		Injury a Work?		280	d. Describe hor			<i>suny)</i>
Divis	To the Hospitel or Attending I within 24 hours after death. To the Funeret Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of tnju building, etc	ury - At ho c. (Specif	ome, farm, sti	reet, factory, o	ffice		28f	Location (Str City or Town,		Number or F	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dircompletely filled in	edical (29a. Certifier 1 € Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	f examina	wledge, deat tion and/or in	h occurred at t vestigation, in	the time my opir	, date and ; nion, death	place, and occurred	d due to the ca at the time, da	use(s) ar te and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier					icense r		r				th, Day, Year)
			Mellefre	nos				-15	994			7-	14-0	3
	4		30. Name and address of person who co	TVE, IT	AUR	E PE	5 GR	CA	CE.	MD	, 2/	078	3	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 6 2	.005 32. Resistra	ar's Signa	iture A	full							

Dorothy Schlottman

Lia	am Fran	ice	s Scriber			artment of Health and	•	_	
			1 - State Registrar			rtificate of Death		Reg. No.2005	31567
· **	Jan de		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith	3. Time of Death
	Physici /Medic		William	Francis	Scribe	r		per 17,2005	12:17 P M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of De	ath	4c. County of Dea	th
1.	- Mr.		Prince George's Ho			Cheverly		Prince Ge	orge's
	Funeral Director	,	5. Social Security Number 6. Sex 150-7022	M 2DE	(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi	in (Month, Day	v. Year) Co	thplace (State or Foreign cuntry)
- 65 ·			Usual Residence of Decedent		10		pept. 30	0, 1946 Mar	yland
	how how		10a. State 10b. County		10c. City, Town or Lo	cation			10d. fnside City Limits
	Ba-1s	cto	Maryland St. Ma	ry's		California			1 ☐ Yes 2 Mo
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f show event. Its Medical Exarcles intelligent collises at	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	ountry?
	s 23s	20	22030 Mojave Driv			20619		United Sta	
	item item	Funerai	11. Marital Status 1 ■ Never Married 2 ■ Married	12. Was Decedent 8 Armed Forces? 1 Page 1 Page 2 Page 1	Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
0000	il, or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1969	1 ☐ Yes 2 ₺ No Specify:		Specify:	Black
5	72 hours after natural', or ite		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupation		16b. Kind of Business	/Industry
7	within 7 ene. then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	kind of work done during most of w DO NOT use retired)	vorking		
V	e filed within al Hygiene. I other then '	ပ္ပ	12		La	borer		Constru	ction
200	d off	Be	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle,	Maiden Sumame)	
2	1 Mer narke	은	James Frankli	Control of the second statement			cia Young		
	nd 2 should be ith and Mental it 27 is marked or recommetic eve		19a. Informant's Name/Relationship (Type			ng Address (Street and Number or			
ย์	permit. Pages 1 and 2 should Department of Health and Mer important: If Item 27 is marke eny injury or other treumatic once.		Mary Cameron / Si 20a. Method of Disposition	ster	20b. Place of Dispo	Staples Street, sition (Name of natory or other place)	N.E., Was	Shington, D 20c. Location - City or	
ращитог	ages ant of it: If it		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			26 2005		
	artme ortan injur		21. Signatur Juneral Surviva License	θ/)		Veterans Cem 9-2 . Name and Address of Facility Bi		Cheltenham,	
ŏ	Depa impo eny i		Edward N. Brinsfie	ld, Jr.	A SECURITION OF THE RESERVE OF THE PERSON OF	955 Hollywood Ko			
	A		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Moon	- 1-	v ries			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	0 (100)			
	Examiner	_	Sequentially list conditions, b						
	ed sit	line	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				
	be executed icien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as	a consequence of):				
00,	e be e /sicien e burië	calE			• //				
	eath certificate be executed attending physicien and for use es the burial-transit		0						
Š	andin use	In/M	fF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth		75-4		23d. Date of del	ivery
0	deat	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Ectopic pregnancy Other (specify)		Month	Day Year
Э	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use es th	Physician/Med	9 Unknown						
ń	res th	by	Part II. Other significant conditions con	Inbuting to death bu	it not resulting in the u	nderlying cause given in Part I.		bacco use contribute to	
necorus,	requi	Completed					1 🗆 Y	es 2 No 3 Pr	obably 4 Unknown
i E	elaw hast	mpi					24a. Was a autops	sy prior to	topsy findings available completion of cause of
							12 Yes	med? death?	2 □ No
<u>8</u>	sician: The faw s certificate has b lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 34 es 2 No	ospital:		0.1	eath (Check only or		
5	iding Phys th: After this funeral dir		27. Manner of Death	28a. Date of Injur		1 3 DOA 4 Nursing		ence 6 Other (Specow injury occurred	cify)
DIVISION	nding ath. r: Afte e fun	atio	1 ☐ Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	_		y Pickuptrum
2	Attendi	Iffice	3 ☐ Suicide 6 ☐ Could not be determined		rv - At home, farm, str		28f. Location (S	treet and Number or Run, State)	ural Route Number,
5	tel or rs afte el Dii	Certification:			Dusy		W/BGRETS	MILLS ROLES	STHAMYIS WHO MINGTON POPUL
	To the Hospitel or Attending Physician: To the Funarel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best of	of my knowledge, death	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the c	ause(s) and manner as	stated
	within To the	Me	29b. Signature and title of certifier	P.		29c. License number		29d. Date signed (Monti	
			I Moyette An	e Kreek	e HD	O.C.M.E.		September 1	8. 2005
			30. Name and address of person who con	npleted cause of de	eath (Item 23a) (Type,		,	- Speciment I	-, 2005
			PLANG MOITO D. KO	RELL	111 Penn	Street, Baltimon	re. Marvla	and 21201	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
SEP 2 1 2005
32. Segistrar's Signature

			For State Registrar	te of Maryland /		artmen rtificat			and Me	ental Hy	giene	2000	31	568
	Physici /Medio	al		chard Schro	th,				2	2. Date of De Month Septem	ber	19, 200		of Death
	Examir Funeral	ier	4a. Facility Name (If not institution, give street a Taylor Farms Assisted 5. Social Security Number 6. Sex 215 44 5232	Living 7. Age (In yrs. last		Bush	wood	If Under 2	_	3. Oate of Bi	S	t. Mary		e or Foreign
	Director		215-44-5232 Usual Residence of Decedent 10a. State 10b. County	10c. City, To	Yrs.				1	anuary				Columbia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, it a Medical Exercity or items in cellified and other.	To Be Completed by Funeral Director	Maryland St. Mary's 10e. Street and Number 21736 Oscar Hayden Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade comp	Bushwo s Decedent Ever in U.S. led Forces? Yes 2 M No se, Give ar or Dates:	13. 6a. Dece (Give life). Mecc. 9b. Maili 26136 etery, cree polit Mar.	10f. Zip 20 Was Decedif Yes, specifi Yes, specifi Yes, specifi Yes dent's Usu: kind of wo DO NOT u: chanic mg Address Woody Stion (Namatory or can matory or can an Crei 2. Name ar thing I	618 dent of Hiscory Cubar 2 No al Occupark done dise retired) a (Street a Court me of the place matory ad Addres e y Gar	Specify: tition uring most 18. Mothe Aile and Number Mecl y S of Facility rediner	en War or or Rural hanics Da ept 2	First, Middle d Route Numb	USA 16b. K Auto a, Maider Per, City of Maryl 20c. L Alex , P.A	14. Race - Am Black, Whi Specify: Whi (ind of Business) motive of Sumame) or Town, State, and 20659 ocation - City or andria - V	1 Ye puntry? sincan Indian, i.e, etc. te //industry	es 2 🖸 No
x 68760,	Physician product of the principle of th	Medical Examiner	resulting in death) Source if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Description of the control of th	ue to (or as a consequence to (or a conseq	ce of):	wea with		, such as	cardiac or	respiratory a	arrest,		Approxim Interval E Onset an	Between
.O. Box		Physician/Medical	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death Unknown	ath 3[□Ectopic pi □ Other (sp						23d. Date of de Month	livery Day	Year
Records, P.	law requires that the death as been signed by the atter 2 should be detached for u		Part II. Other significant conditions contributing INDULY Approach de de la contribution	g to death but not resultin	g in the u	inderlying o	ause give	n in Part I.				use contribute to	o the cause o	
	The ate his page	Completed by	hyperboldenna, mi	ked						24a. Was auto perf 1 Yes		death?	completion of	is available cause of
Division of Vital	Attending Physician: Throdent. octor: After this certificate by the funeral director, pag	ation: To Be	1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EH/	Outpatie b. Time o Injury		28c. Injury Work	r: 4 🗆 Nui	rsing Home	Check only e 5 ☐ Res d. Describe	idence	6 Other (Spery occurred	city ASS iS	kd living
Divis	or or Direction	il Certification:	3 Suicide 6 Could not be determined 28e. 29a. Certifier 1 Certifying Physician:	Place of Injury - At home building, etc. (Specify)				o data an		City or To	wn, State			ımber,
	To the Hospitel within 24 hours of To the Funerel completely filled	Medical	(Check only 2 Medical Examiner: Or	the basis of examination d manner stated.	and/or ir	vestigation	, in my op	inion, deat	th occurred	at the time	, date an	d place, and du	to the cause	
	SAE		30. Name and address of person who complete	d cause of death (Item 23	a) (Type,	Print)	28	544				tmber d d 206		
	Str	ate	Collein D. Jude 23511 to 31. Date filed (Month, Day, Year)	1000000 ST 32. Registar's Signature	uet,	Suit	5101	Less	naid	toun,	M	d 206	50	
	Regist		SEP 2 2 200		K	April								

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of M	laryland / Del	partment of ertificate of	Health and I Death		Reg. No.	05	
	Physici	an	Decedent's Name (First, Middle,	Last)				2. Date of Dea	Day	Year	3. Time of Death
	/Medic			yre		1		09	12	05	7:20 A M
	Examin	er	4a. Fecility Name (If not institution, Sligo Creek Nu	rsing Home		Takom	or Location of Death			gomer	
	Funeral Director		577-32-7351	6. Sex 7. A 1 □ M 2 🖾 F	ge (In yrs. last birthda 78 Yrs.	Months Days		8. Date of Birl (Month, Pa 07	y, Year) 27	9. Birthpla Countr Wash.	D . C .
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	d. Inside City Limits
	Many a-f sh	to	MD Montgo	mery	Silver	Spring					1 ☐ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	y?
	ath w	rail	321 University			2090			USA		- Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumstic event, the Medical Examinational Be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 A Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	§ No	8. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S ban, Mexican, Puert o <i>Specify</i> :	pecify Yes or No o Rican, etc.)		ce - America ick, White, et fy: Blac	tc.
Š	2 hou	ted	15. Decedent	s Education	16a. De	cedent's Usual Occi	upation	kina	16b. Kind of E	Business/Indu	ustry
21215-0036	thin 7 e Med	npie	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	. DO NOT use retir	e during most of wor red)	Kiilg	Joseph	Kenne	dy
2	ed wi	Co	12th.		S	ecretary	10 Mathada Nas	ne (First, Middle,	Institu		
Maryland	2 should be filed within and Mental Hygiene. is marked other then seumstic event, the Mental forms and the Mental forms the M	Be	17. Father's Name (First, Middle, L					ansfield		төј	
7	should be t and Mental & s markad of umatic eve	ဥ	William H. Joh		19b. Ma	iling Address (Stree	et and Number or Ru			. State. Zip C	CodeD \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Ma	d 2 s Ith an 27 is r treui		Lewis Smyre/Sp				ty Blvd.				
	Health tam 27 other to	N 3	20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other p		Date	20c. Location		
9	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		0	incoln Ce		- 05	Brentw	ood, M	D .
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tre <u>once</u> .		21. Signature of Funeral Service L		00	22. Name and Add	ress of Facility MA1	shall's	Funera	1 Home	:)11
	Prysician		23a. Pan1 Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aVentri	ed the death. Do not line. Cular Arri	enter the mode of dy	ying, s <i>u</i> ch as cardiac	or respiratory a	rrest,	i	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or a	as a consequence of):						
8760,	eath certificate be executed attending physician and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	as a consequence of):						
9	rtificate I ng physi as the b	Medica	IS SEMALE.	d							
P.O. Box	the death ceily the attendii	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	3 □ Ectopic pregnar 5 □ Other (specify)				ate of deliver onth [y Day Year
	w requires that the deben signed by the should be detached	by	Part II. Other significant condition Dementia	ns contributing to death	but not resulting in the	underlying cause (given in Part I.		Did tobacco use contribute to the cause of		
Vital Records,	2 5 8	Completed	Cerebrovascu	lar Accider	nt			24a. Was		Were autop: prior to com death?	sy findings available pletion of cause of
a F	Th ate pag		Hypertension					1 ☐ Yes	2 X No	1 ☐ Yes 2	2□ No
Z.		Be C	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpa	itient 2 ☐ ER/Outpa	100 A	ther	ath (Check only o		har (Casain)	
of	ding h. Atter fune	ition; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of In (Month, L	The second secon	of 28c. In	- Vinuising r	lome 5 ☐ Resi 28d. Describe			
Division	tor the	Certification;	3 Suicide 6 Could r 4 Homicide determi	28e. Place of building,	Injury - At home, farm, etc. (Specify)	street, factory, office	9	28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C		g Physician: To the be Examiner: On the basis and manner	of examination and/o						
	To th within To th comp	Me	29b. Signature and tille of certifier			29c. Lice	nse number	The state of the s	29d. Date sign	ed (Month, D	lay, Year)
				/		56	147		09-14-0	15	
R	(10)		30. Name and address of person	who com - ed cause o	f death (Item 23a) (Ty	e, Print)				31.00	
1			Nasreen Kango,	M.D. 7610	Carroll	ve. #205	Takoma Pa	ark, MD.	20912		
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 5 2		strar's Signature	and					

			1 - State Registrar	State of Ma		rtificate of		Reg. I	211115	31571
° Pi	hysici	an	Decedent's Name (First, Middle, La. M	st) IARGARET I	OUTSE TI	HURSTON			ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		JOOIDE II		r Location of Death	SEPT. 14	2005 c. County of Death	3:56 P M
9 2			CARROLL HOSPIT 5. Social Security Number 6. S		(In yrs. last birthday)	WESTI	MINSTER If Under 24 Hrs.	8. Date of Birth	CARROLL	place (State or Foreign
	ineral rector		229-36-3106	□м ЖОГ	73 Yrs.	Months Days	Hours Min.	(Month, Day, Yea 8/1/193	vir) Con	place (State or Foreign intry) INIA
yland	Mot		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo		A			10d. Inside City Limits
he Mar	sa-fs	Director	MD CARROL	L	WESTMI					1 X Yes 2 □ No
death with the Maryland	d other than "natural", or liams 23s or 28a-f show avant, if a Medical Exercit art mat be notified at		10e. Street and Number 12 KEMPER AVE	•		10f. Zip Code 211	57		Citizen of What Cou JSA	intry?
er deat	tams 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
1215-0036 within 72 hours after	al, or Every	by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ŽŽŽŽVo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	HITE
15-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	dent's Usual Occup	pation during most of working	g 16b.	Kind of Business/l	ndustry
212 d within giena.	ar than	omo	Elementary/Secondary (0-12)	College (1-4or 5+		IETARY (ATE HOS	PITAL
and 2 I be filad ntat Hygir		Be	17. Father's Name (First, Middle, Last,) DANIEL GRA	ATTEN SHI	RADER		(First, Middle, Maid FAY BOWL		
	itam 27 is markad othar traumatic av	၉	19a. Informant's Name/Relationship (and Number or Rural			p Code)
	ım 27 li har tra		LEROY C. THURST	ON -HUSBA	AND 12 KI	No. of Contract of			•	
Baltimore, parmit. Pages 1 ar Department of Hea	nt: If ita ry or of		Burial 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Specif		cemetery, crer	matory`or other pla	^{∞)} ERY		Location - City or T STMINST	
Balti parmit. Departm	Important: If i any injury or o once.		21. Signaturi a Prograf Price Licer				ss of FacilityFLET			
	- a O		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t			AIN ST., V		TER, MD	Approximate
Priys	si ci an -		shock, of heart failure. List only Immediate Cause (Final disease or condition			And and a second	nalopath			Interval Between Onset and Death
	edical miner		resulting in death)	Due to (or as a	consequence of):			1		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
xecutac	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
68760, lificate be executed	physician and s the burial-transit	edical E		_ d						
	ding ph		IF FEMALE:	23c. If yes, outcome of	i prognancy					
BOX	e attending p	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)	<u>′</u>		23d. Date of deliv Month	Pery Day Year
P.O.	signed by the a	Phys	9 ☐ Unknown Part II. Other significant conditions of	9 ☐ Unknown	not resulting in the u	ndorhing onuco civ	on in Port I	23a Did tohaco	uco contributo to	the cause of death?
I Records, P.O. Box The law requires that the death cer	n signe		Takin other significant conditions		not resulting in the di		en in Fait i.			bably 4 Dunknown
law rec	has been si	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	ate pag		25. Was case referred to medical					performed?		2□ No
	certific	Be	examiner?	Hospital:	2 ER/Outpatien	nt 3 DOA Cth	er: 4 Nursing Hom	e 5 🗆 Residence	6 □Other (Speci	60
	S E	2	1 ☐ Yes 2 ☐ No	1 Inpatient		IL DON				(y)
on of	After this uneral dii	tion: To	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day		f 28c. Injur Wor	y at 2	8d. Describe how in	ury occurred	9)
VISION OF Attanding Phy ar death.	After this uneral dii		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	f 28c. injur Wor M 1 🗆	y at 20 k? Yes 2 □ No	Bf. Location (Street	and Number or Rur	
OIVISION OF or Attanding Phatter death.	Diractor: After this in by the funeral di	Certification:	27. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 4 Homicide Homicide	28a. Date of Injury (Month, Day) e 28e. Place of Injur building, etc.	Year) 28b. Time of Injury y - At home, farm, str (Specify)	f 28c. Injur Wor M 1 eet, factory, office	y at 21 k? Yes 2 □ No	Bf. Location (Street) City or Town, Sta	and Number or Rur te)	al Route Number,
	Diractor: After this in by the funeral di	Certification:	27. Manner of Death 1. Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Ph	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury y - At home, farm, str (Specify) my knowledge, death examination and/or in	f 28c. Injur Wor M 1 eet, factory, office	y at 20 K? Yes 2 No 20	Bf. Location (Street and City or Town, Sta	and Number or Rur te)	al Route Number,
DIVISION OF To the Hospital or Attanding Phy within 24 hours after death.	Diractor: After this in by the funeral di		27. Manner of Death 1. Natural 2	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. Tysicien: To the best of injure: On the basis of e	Year) 28b. Time of Injury y - At home, farm, str (Specify) my knowledge, death examination and/or in	deet, factory, office	y at 2: k? Yes 2 No 2: ne, date and place, ar pinion, death occurred a number	Bf. Location (Street and City or Town, Standard due to the caused at the time, date a	and Number or Run te) s) and manner as s nd place, and due to	al Route Number, stated. o the cause(s) Day, Year)
	Diractor: After this in by the funeral di	Certification:	27. Manner of Death 1. Natural 2	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. 1. To the best of niner: On the basis of eand manner state	Year) 28b. Time of Injury y At home, farm, str (Specify) my knowledge, death examination and/or invad.	Beet, factory, office n occurred at the time vestigation, in my course 29c. Licens	y at X? Yes 2 No 20 me, date and place, as pinion, death occurred e number	Bf. Location (Street and City or Town, Standard due to the caused dat the time, date and 29d. D	and Number or Runte) s) and manner as s nd place, and due to ate signed (Month,	al Route Number, stated. o the cause(s) Day, Year)
To the Hospital	Diractor: After this in by the funeral di	Medical Certification:	27. Manner of Death 1. Natural 2	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. Tysicien: To the best of and manner state	Year) 28b. Time of Injury y At home, farm, str (Specify) my knowledge, death examination and/or invad.	Beet, factory, office n occurred at the time vestigation, in my course 29c. Licens	y at X? Yes 2 No 20 me, date and place, as pinion, death occurred e number	Bf. Location (Street and City or Town, Standard due to the caused at the time, date a	and Number or Runte) s) and manner as s nd place, and due to ate signed (Month,	al Route Number, stated. o the cause(s) Day, Year)

	i,			Please T					k. Assure A	-		_	
					State of Ma	ryland / [Health and I	Mental Hy	giene,	2000	01==0
	AMEN)#7	7,10b,10dper	TH9/14/05,BM	W,MbCb		Certi	ficate o	f Death		Reg. No.	2005	31573
	Physicia: /Medica			a <i>(First, Middla, Last)</i> larie Udes						2. Date of De Month	Day	Zoor	3. Time of Death 9:35 Am
	Examine			ll not institution, giva s lospital	treet and number)				4b. City, Town, or t Baltimor		h 4c. (County of Deeth	
	Funeral Director		5. Social Sacurity N 216-56-5			(In yrs last bii		If Under 1 Yas Months Day		8. Data of Bir July 2	b Year	9. Birth Ba ⁹⁰	placa (State or Foraign Timore, MD
	P B		Usual Residence of	Decedent 10b. County		10c. City, Tow	n or Locat	tion					10d. Insida City Limits
	daryte f sho	៦	MD	Harford		Belca							1 ☐ Yas 2X No
	the h	2	10e. Street and Nur	mber		50.00		10f. Zip Code	0		10g. Citiz	an of What Cou	ntry?
	h with	ᅙ	1277 Cc	ollier Lane	;			21017	7		Uni	ted Sta	ites
	deet deet	i e	11. Marital Status	1	2. Was Decedent E Armed Forces?	ver in U,S.	13. Wa	s Decedent of	Hispanic Origin? (Sp ban, Mexican, Puart	pecify Yes or No	- 1	4. Race - Amari Black, Whita	
0020	filed within 72 hours eftar deeth with the Maryland Hygiene. ther than "naturel", or Nema 23a or 28a-f show ent, the Medical Examinet must be notified at	Completed by Funeral Director	1 Nevar Marri	ied 2☐XMarried 4☐Divorced	1 ☐ Yes 2 N If Yes, Give Yaar or Detas:	0		Yes 20 N				Specify: Whi	te
5-(netu netu	ete e	(Ѕрес	15. Decedent's Educ cify only highest grade	ation completed)	16a	(Give kin	it's Usual Occ	upation e during most of wor ed)	king	16b. Kin	d of Business/Ir e Arunde	el County
212	withir day	E C	Elementary/Seco	ondary (0-12)	College (1-4or 5-	') T	each		60)		1		lucation
Maryland 21215-0020	8 2 2 2	To Be C	17. Father's Name Raymond F	(First, Middle, Last)	<u>.</u>				18. Mother's Nam Vera Tr	ne (First, Middle ageser			
	12 a a a		19a. Informant's Na James T.	ame/Relationship (Tyr. Udes / Hus	sband	19t	Mailing (Address (Stre COITE)	et and Number or Ru Lane Bel	camp, M	Ď 210	Town, State, Zi 17	o Coda)
Baltimore,	Pages 1 and nent of Healt ant: if Itam 21 ury or other			position Cremation 3 Re 5 Other (Specify)	emoval from State	20b. Place o cemete Howar	ry, cremat	on (Name of lory or other p	chool	Date 9/13/05		ation - City or T ington :	
Balt	permit. Pages Depertment of Important: If It eny Injury or once.		21. Signature of Fe	neral Service License	е	>			ress of Facility Syster Fun Street N			nc 20	0011
			23a. Part1. Enter to shock or haa	ha disaasa, or complic in failura. List only on	ations that caused a cause on each line	tha death. Do	not enter t	the mode of d	ying, such as cardiac	or raspiratory a	rrest,		Approximate Interval Between
)	Physician /Medical		Immediata Causa (diseasa or condition			Ant			ARY EMI			an	Onset and Death
	Examiner		rasulting in death)	a a		Due to (or es a			1. 1	evel).		1	•
	si ed	amine		_ b		Deep 1	VEIN	THROM	1BOSIS			Los	uc standing
	0 57	Exal	Sequantially list co	nmediate	C	Due to (or es e	conseque	nce of):					
68760,		_	cause. Enter Unda Ceuse (Disaasa or that initiated evants resulting in death) if	injury c.		Dua to (or as a	consequer	nce of):					
9 X	eeth certificete b ettending physic d for use as tha b	M W		d								1	
Вох	eeth c	Clan	D	li a dial	Maria a de de la francia				river is Deat I	nosh Divi	tabassa	an contribute t	o the causa of death?
P.O.		Physician/Medica	Die Lotz	icant conditions cont	Lupu	,		12 TETUSI			Yes 2		bably 4 Miknown
	as the gane	6	-400 416	5 / 4111 (00)	, -10, 00	, .	3/5	12 (0/0)[,,,,	24a Was	an autops	24b W	ere autopsy findings
Records,	The lew requir ate hes been si pege 2 should	Сощріете	MITRHL	VACUE F	ROLHPS	E V	EN I	RICILL	AR	perfo	ormed?	a av	railable prior to empletion of cause death?
<u>e</u>	cate he			CARDIA	, Skin A	JELRO	515			10	Yes 2	No 1	☐ Yes 2☐ No
of Vital	¥ 5 E	o ne	25. Was case refer examiner?		ospital:	a □ ED#	dnatic=1	2[] DOA [G	26. Place of Dea			Other (Carri	6.1
	A SED	- 1	1 ☐ Yes 2 2 27. Menner of Deat	h _	28a. Date of Injury	t 2 □ ER/Ot	Time of	28c. Ini	4 LI Nursing H	ome 5 ☐ Rasi 28d. Describe)y)
ion	Attending is death. actor: After by the funer	atio	1 Natural 2 Accident	5 Pending invastigation	(Month, Day	(dai)	njury		ork? ☐Yes 2☐No				
Division	ours after death ours after death oral Director: filled in by the	Certification:	3 ☐ Suicida 4 ☐ Hornicide	6 Could not be detarmined	28e. Place of Inju building, atc.		ırm, street	, factory, offic	9	28f. Location (City or To		Number or Rur	al Route Number,
		dical	29a. Certifiar (Check only one)	1 Certifying Physical Examin		examination an							

29c. Licensa number D0000 1346 29d. Date signad (Month, Day, Year) Sept. 9

PT. 9 2005 Nd. 2123D St BALTIMORE 30. Nama and addrass of person who considered cause of death (Item 23e) (Type, Print)

1. FLYNN NI WIVERSITY SPELIALTY INSPIRAL, 611 South CHARLES

31. Data fillad (Month, Day, Year)

SEP 1 4 2005

32. Registrar's Signature

State Registrar

				epartment of Health and Mental Hygiene Certificate of Death Reg. N 2 0 0 5 3 5 7 4
I	Physici	ian	Decedent's Name (First, Middle, Last) Gwendolyn Mills Underwood	2. Date of Death Month Day September 9, 2005 3. Time of Death 2:20A M
	/Media	cal	4a. Fecility Name (If not institution, give street and number)	September 9, 2005 2:20A M 4b. City, Town, or Location of Death 4c. County of Death
1	Examir	ier	7603 Elmore Lane	Bethesda Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min (Month, Day, Year) 9. Birthplace (State or Foreign
	Director		226-56-3149 1 M 223F 62 YI	April 24,1943 Virginia
	land land		10a. State 10b. County 10c. City, Town	or Location 10d. Inside City Limits
	Man e-f sh	ţċ	Virginia Alexan	dria 1 □Xyes 2 □ No
	or 28	Direc	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	s 23a	rail	508 N. Jordan St. #302	22304 USA
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, the Medical Examerar must be notified at	Completed by Funerai Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 hor	eted	15. Decedent's Education 16a. D (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work doze during most of working. 16b. Kind of Business/Industry
21215-0036	nithin ne. hen	mple	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working life. DO NOT use retired) Case Manager Northern Virginia Social Services
	Hygie Hygie thert			Social Services nsitional Housing 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame)
lan	id be ental ked o ic eve	To Be	A11 TT M. 11	Loretta Bernice Keyes
Maryland	nd 2 should be filed within alth and Mental Hygiene. 27 Is marked other then r freumatic event, the Me	-		Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health em 27 I			N. Jordan St. #302 Alexandria, Virginia 22304
Baltimore,	00		1 Rusial 2 Cromation 2 Removal from State cemetery,	Disposition (Name of crematory or other place) y Crematory 09/14/2005 Alexandria, Virginia
Balt	permit. Pag Department Importent: I any injury o once.		21. Signatury of Fundral Service Licenses	22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W. Braddock Rd. Alexandria, VA 22302
ı			234. Part1. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	of enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	20 fre CONCR Monte
1	/Medical Examiner		Due to (or as a consequence of))
		-e	Sequentially list conditions, if any, leading to immediate causs. Enter Uncertaing Cause (Disease or Injury):
	cuted	Examiner	that initiated events C.	
8760,	be executed sician and burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of)	6
687	fficate I g physi	edic	d	
Вох	death certific attending pl	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 23d. Date of delivery 5 ☐ Other (specify) Month Day Year
P.0	at the de by the tached	hysi	9 Unknown	
	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown
of Vital Records,	The law rate has be	Completed		24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Ves 2 No
/ital	ilcien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
of V	Physicien: this certificatal director, p	ဥ	1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	
uc.	ing After une	:lou:	27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Tim Injury	ne of 28c. Injury at 28d. Describe how injury occurred
Division	tten deat tor: the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm	
á	itel or a ster safter el Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospitel or Al within 24 hours after or Ito the Funeral Directompletely filled in by	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not be basis of examination and/or and manner stated.	death occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	To the complet	Ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
2	(10)		30. Name and address of person who completed cause of death (Item 23a) (Ty	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 2005	14 CFC 1 200 CC J 2327

			1- For Amend Ite	ns 25,27,	Marylar 2 8a-f j	nd/Depa per MC	artment of Hi CB47 097 tificate of L	ealth and N 28/05dhb Sealth	Mental Hyg	giene Reg. N2 0 0 5	31575
	Dharini		1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Elsie Ellen Wi	lkinson					Sept	Day Ye 200	_ 44
1	Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, or	Location of Death		4c. County of D	eath
			Carroll Hospita					inster		Carr	oll
	Funeral			3. Sex 7 1 ☐ M 2 ☐ X F	'. Age (In yrs.	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		214-28-0937 Usual Residence of Decedent			93 118.			Aug 0	6 1912	MD
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Man	ţo	MD Car	roll		Moden	inster				1 ☐ Yes 2 ∑ No
	r 28g	Irec	10e. Street and Number			Wesu	10f. Zip Code			10g. Citizen of What	Country?
	th wit	Funeral Director	1442 Allen Way				21	1157		USA	
	deal	ner	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-	14. Race - A	merican Indian,
9	after or ite		1 ☐ Never Married 2 ☐ Marrie		2 No		Yes 25√No	Specify:	nican, etc.)		/hite, etc.
8	ural',	d by	¥☐ Widowed 4 ☐ Divorced	Year or Dat	tes:		234110			Specify:	White
5	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23e or 28e-f show ther than "natural", or items 12e rodified at out, the Medical Evanture innet the rodified at	Completed	15. Decedent's (Specify only highest			(Give	lent's Usual Occupa kind of work done di	uring most of work	king	16b. Kind of Busine	ess/Industry
12	withii ene. than	ш	Elementary/Secondary (0-12)	College (1-	4or 5+)	1116. 2	OO NOT use retired)			O II	
d 2	be filed within 72 hours after death with the Marylan hal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Evantian from the notified at		17. Father's Name (First, Middle, Li	ist)			Homemaker		e (First, Middle.	Own Ho	me
Maryland 21215-0036	12 should be filed within 'n and Mental Hygiene. 7 is marked other than "Iraumatic event, the Med	To Be	Frank Shaeffer						Tressle	·	
ary	shound M	_	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address (Street a			or, City or Town, State	e, Zip Code)
	and 2 sealth are n 27 is		Christine Brehm	/daughter		1442	Allen Wa	ay Westn	minster,	MD 2115	7
J.	- T = =		20a. Method of Disposition	Domesister C		Place of Disponentery, cren	sition (Name of natory or other place)	Date	20c. Location - City	or Town, State
Ĕ	Pa nen ant: ury		1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		Kr:	iders (hurch Cen	n 9/12	2/2005	Westmin	ster, MD
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Li	censee		2 <u>2</u> H	Name and Address	s of Facility neral Hon	ne and C	hapel, P.	A. 21157
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that car	used the deat	h. Do not ente	or the mode of dying	igton Roa , such as cardiac	or respiratory ar	minster, l	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-	ZACTO	124	Righth.	D			Onset and Death
	/Medical		resulting in death)	a	r as a conseq					1	Stan
	Examiner		Sequentially list conditions	b. —————					1		1
	sit ad	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseq	uence of):		ENTIFICA ON APPRI	1. Loical	EXAMINER	
	xecut and al-trar	Examln	that initiated events resulting in death) Last	c. Due to (o	ras a conseq	uence of):		N. NPPR	ONED BY WED!		
8760,	icate be executed physician and s the burial-transit	dlcal E		d -			CE	RTIFICATION			
89	ifficati g phy as the	e e		u.							
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	ancy	r*			23d. Date of	delivery
	death	sicia	in the past 12 gronths? 1 ☐ Yes 2 ☐No		nt at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	at the de by the a	hys	9 Unknown								
	es tha igned be det	by F	Part II. Other significant condition			ulting in the ur	derlying cause giver	n in Part I.			to the cause of death?
ord	w require been si should b	ted	Jeans	17 ENCE	INT				1 🗆 Y	es 2 💢 Vo 3 🗆	Probably 4 🗆 Unknown
Vital Records,	2 2 2	ompleted							24a. Was a autops	sy prior 1	autopsy findings available to completion of cause of
E H		Co							perfor	mgg? death	? es 2□No
Vite Sign	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Deat	h (Check only or	ne)	
4	Phys this al dir	To.	1 Xes 27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of	3 □ DOA Other	4 Nursing Ho		ence 6 Other (S) ow injury occurred	pecify)
Division	ding h. After fune	tlon	1 Pending	(Month,	Day Year)	Injury	Work?	?	Subject		
İSİ	Atten deat ctor: y the	flca	3 Suicide 6 Could no	t be on Bloom		Unknow Ome, farm, stre	et, factory, office				Rural Route Number.
ō	al or a after i Dire d in b	Certification;	4 Homicide	building	g, etc. (Specify	1/)	At home	915			Rural Route Number, Allen Way
	To the Hospital or Attending Pr within 24 hours alter death. To the Funeral Director: After the completely filled in by the funeral	65	Check only 2 Medical Ex	Physician: To the b	est of my kno	wiedge, death	occurred at the time	e, date and place.	and due to the c	ster, MD ause(s) and manner late and place, and d	as stated.
	thin 2 the mplet	Medica	one) 29b. Signature and title of certifier	and manne	r stated.		29c. License			29d. Date signed (Mo	
1	5 7 K 1			k. Ga	کارس ر	ممم يت	-				
	10		30. Name and address of person wi	no completed cause	of death (Item	23a) (Type, F	Print)			091086 Minister 1	
	10		THOMAS	K. CAW			STONEZ	- Avenue	West	ninistea m	nauntard
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ture		-			
		3 i	SEP 2 8 2005	M.	20 A	. 18 .					

		1 - For State Registrar	State of	f Marylar	nd / Depa <i>Cer</i>	artment of F	lealth a <i>Death</i>	ind Me	ntal Hyg	iene 0 ()5	31576
Physicia		1. Decedent's Name (First, Middle, I John Richard		aker					Date of Death Month Sept.	Day	Year 005	3. Time of Death
/Medic Examin		4a. Fecility Name (If not institution, g				4b. City, Town, o	r Location of			4c. County		12.500
4		Glen Burnie					n Bur			Anne		undel
Funeral Director		5. Social Security Number 6 150-12-9256 Usual Residence of Decedent	Sex 1 Mg M 2 □ F	7. Age (In yrs. 79	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, lay 19,		9. Birthpl Count	ace (State or Foreign ry) NJ
land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Limits
Many B-feh	tor	MD Anne	Arundel			Mil	lersvi	lle				1 ☐ Yes 2 🙀 No
ith the	Dire	10e. Street and Number				10f. Zip Code			10	Og. Citizen of V	Vhat Coun	ry?
s 23m	erai	8354 Sycamore	Road	dest Ever in 1	16 112 1		108	-i=2 /C===if	Vaa aa Na	14 Page	USA - America	no Indian
portition of the proof of the p	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	rces? 2 □ No W	WTT	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No		, Puerto Ric	an, etc.)		k, White, e	
72 ho	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual Occup	durina most	of working	1	16b. Kind of Bu		ustry
Men Men	mple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	1)			R.S. S		
Hygie ant, In		12 17. Father's Name (First, Middle, La	st)		511	ip Chand		r's Name (F	irst. Middle. N	U.S. N		
y call	To Be	Unavailable			1.2		Unav	ailab	le			
INCII		19a. Informant's Name/Relationship Helen Whittake				Sycamore						
Description of the majority of He majoritants if item my injury or oth the the the majority or oth the the the the the the the the the t		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			cemetery, crer	sition (Name of natory or other place ren Cemet	ery		. 12, 2005	Glen I		
permit. Depertrimports eny inji		21. Signature of Funeral Service Lic	ensee ALC	en	13 13 4	Name and Address arranco 8 95 Gov. 1	ss of Facility & Sons Citchi	, P.A	. Seve	rna Par rna Par	k Fur k, MI	neral Home 21146
7 4		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca ty one cause on ea	aused the deal								Approximate Interval Between Onset and Death
Physician /Medical Examiner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	bDue to (or as a consec	juence of):							
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnancy Other (specify)	,			23d. Date Mor	e of deliver	y Day Year
requires that	by	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.			_	ibute to the	e cause of death?
ding Physician. The law red fing Physician. The law red h. funeral director, page 2 shou	Completed								24a. Was an autopsy perform	/ p led? d	rior to com	sy findings available pletion of cause of
vician: dician: certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:		1500	Oth	O.F.		Check only one			
nding Phys th. r: Alter this e funeral di	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Paccident investigat	28a. Date of		28b. Time of Injury	28c. Injun Worl	4 Nur	28d		nce 6 Other		
l or Attendate death Director:	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury · At h	ome, farm, str fy)	eet, factory, office	103 2 210		Location (Str. City or Town,	eet and Numbe State)	or Or Rural	Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 PCertifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the ba and mann	asis of examina	owledge, death ation and/or in	n occurred at the tire restigation, in my o	ne, date and pinion, death	place, and h occurred	due to the ca at the time, da	use(s) and mar te and place, a	ner as sta nd due to	ited. the cause(s)
To th within To th compl	Me	29b. Signature and title of gertifier	4.4			29c. Licensi			29	d. Date signed	(Month, E	Pay, Year)
		JOUN.	MO			D 38	958			9/9/3	フ	
		30. Name and address of person wh	o completed caus	e of death (Iter	m 23a) (Type,	D		1.0	1		0 1	
		Da Jeef Starle. 31. Date filed (Month, Day Year)	Sidhu	208 () eg (rar's Signa		chuay S	. W.	Olei	n Bush	ue M	1) 21	061
Sta Registr			3 2005	Bellen.	13	(Cooks						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Amend23c,25,2		aryland / Der per ME, 29	partment of per DVR (Sertificate of	Health and 68 6/26/0 Death			2005	0 1	577
3	Physici /Medic	_	Decedent's Name (First, Middle, Gerald Allen W					2. Date of D Month	Death Day	Year 2005	3. Time o	of Death
)	Examin		4a. Fecility Name (If not institution,				or Location of De	ath		County of Dea	_	
			St. Mary's Hosp 5. Social Security Number		e (In yrs. last birthda	Leonard	town r If Under 24 H	rs. 8 Date of B		St. Mary		or Foreign
	Funeral Director		220-84-9114	1 X M 2□F 44		Months Days			1961		thplace (State ountry)	or roreign
	D >		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						20.11.2
	farylan show	5									10d. Inside C	s 2 No
	the N	Director	MD St. Ma 10e. Street and Number	ry's	Mechanic	10f. Zip Code			10a. Cit	izen of What Co	<u> </u>	
	h with		39877 New Marke	t Turner Roa	ad	20659	9		-	ed Stat	_	
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or liems 23s or 28e-f show event, I're Medical Examination must be notified.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S. 13		Hispanic Origin? ban, Mexican, Pu			14. Race - Ame Black, Whit	merican Indian,	
21215-0036	within 72 ho ene. than "netur to Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		(Giv 5+)	edent's Usual Occure kind of work doning DO NOT use retire	e during most of wed)	vorking	16b. Kind of Business/Industry			
9	illed Hygid other	Be C	17. Father's Name (First, Middle, L	ast)	DLyw	all hecha		lame (First, Middl		ilding Sumame)		
ılan		To B	Charles H. Wood	d			Anna Lo	orraine 1	Pirne	r		
Maryland	2 sho and ? is ma	ľ	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	iling Address (Stree	et and Number or	Rural Route Num.	ber, City o	r Town, State, 2	Zip Code)	
	s 1 and 2 should if Heelth and Mer item 27 Is marke other treumatic		Deborah C. Wood 20a. Method of Disposition	/ Wife	3987 20b. Place of Dis	7 New Man	ket Turi	ner Rd. 1		nicsvil		20659
Baltimore,	00		Burial 2 Cremation 4 Donation 5 Other (Sp	ecity)	cemetery, cr	ematory or other pl Memorial	9-1	4-2005	Wald	orf, Ma	ryland	
Bal	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service L Kyle S. Simo	17/1	Jenen 3	22. Name and Addi 019 5 Thre	ress of Facility B1 ee Notch	insfield Road, Cl	d-Ech nar1o	ols Fun tte Hal	eral Ho 1, MD 2	оте, РА 20662
8760,	Physician /Medical Examiner prize pe executed physician end physician end physician it is prize transit.	ilcal Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Sever Due to (or as b. Cardi Dua to (or as Cocains c. Nares	re Anoxic a consequence of): opulmonar a consequence of): intoxication tie Overd a consequence of):	y Arrest on	ppathy				Interval Be Onset and	
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnan	су			23d. Date of del Month	,	Year
rds, P	quires that in signed i uld be det	by	Part II. Other significent condition	ns contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.			ise contribute to	othe cause of obably 4 🗌	
al Records,		Completed						per 1 ☐ Yes	opsy formed?	prior to death?	utopsy findings completion of a	available cause of
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 X Yes	Hospital:	ent 2 ER/Outpati	ent 30 DOA O	26. Place of D ther: 4 \(\sum \) Nursing	eath (Check only		C Other (Can	0.6.1	
J of	g Phy er this		27. Manner of Death	28a. Date of Inju		of 28c. Inju		28d. Describe			cii y)	
sior	Attending I ir death. ector: After by the funer	atlo	1 □Natural 5 □ Pending 1 □ Accident investigs 3 □ Suicide 6 □ Could no	ation 9-6-200			Yes 2 XNo	Cocain		erdose		
Division		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	Find building, et	ury - At home, farm, s c. <i>(Specify)</i> nn Motel	street, factory, office		28f. Location City or To	(Street and own, State)	d Number of Ru Fnd: 25 F n, Mary	ark Ave. Land 20	1 <i>ber,</i>
	To the Hospitel or within 24 hours aff To the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one)	Physician: To the best xeminer: On the basis of and manner sta	f examination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death oc	ce and due to the	e cause(s)	and manner as	stated	
	To the To the To the Comp	Ň	29b. Signature and title of certified	1		29c. Licer	ise number		29d. Dat	e signed (Monti	h, Day, Year)	
			Ind	My The	m	D142	85		Septe	mber 22	2,2005	
			30. Name and address of persons	1								
200/0	C		William D. Boyd 31. Date filed (Month, Day, Year)		Point Look ar's Signature	cout Road	Leonard	town, Ma	ry1an	d 20650)	
1	Sta Registr	ar	SEP 2 3	2005	m B A	god .						
DH	MH 17 Rev 1/2	001	AM A		V. J.	-						

			1- State of Maryland / Depar 23a per Dr., G855, O5/	tment of H 19706dbt incare of t	ealth and M Death	lental Hyg	giene 0	05	315	78
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Elva Elizabeth Wharton	4h Cih Taur	Lassies of Dooth	2. Date of Dea Month 09	13	2005	3. Time of 6:45	Death P M
	Examir	er	WICOMICO NURSING HOME	SALIS				OMICC)	
ľ.	Funeral Director			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/4/191	Year)	9. Birthp Coul Mary	place (State of otry) Land	r Foreign
	aryland show	7	10a. State 10b. County 10c. City, Town or Loca Maryland Wicomico Salisbury					1	0d. Inside Cit	
	h the M r 28a-f	Funeral Director	10e. Street and Number	10f. Zip Code			10g. Citizen of	What Cour	1 ☐ Yes	∠
	eath wit	eral D	701 W. Morris Leonard Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21804		and Van and I	USA	e - Americ	an India	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-f show any injury or other traumatic event, If a Modical Examiner must be notified at once.	by	Armed Forces? If Y 1 □ Never Married 2 □ Married 1 □ Yes 24 □ No	Yes, specify Cubar	spanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Bla	ck, White,	etc.	
15-0	in 72 ho "natur	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupa ind of work done do O NOT use retired	ition luring most of works)	ing	16b. Kind of B	usiness/în	Justry	
212	filed with Hygiene. other ther	Comp	12 Cafete	eria Mana	ager		Public		ol Sys	stem
land	ild be fill lental H ked oth	To Be	17. Father's Name (First, Middle, Last) Arthur Coopman Harrison		18. Mother's Name	ay Harr		ne)		
, Maryland 21215-0036	and 2 should seath and Men n 27 is marke ner traumatic				nd Number or Rura S Leonard					
ltimore,	Pages 1 and of He		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State **Wicometers, cremation** Wicometers, cremation** Wicometers, cremation**	ion (Name of tory or other place Nemorial	9/16		20c. Location			
Baltin	permit. P Departme Importen any injuri 2005e.		14 □Donation 5 □Other (Specify) Park 21. Signature of Fugeral Service in usee 12. No. 12. N	Name and Addres	of Facility uneral Ho will Rd.,	ome Prof	Salisb Sessiona	al As	sociat:	ion
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter thook, or heart failure. List only one cause on each line.					2100	Approximate Interval Betw	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. FAILURE TO Due to (or as a consequence of):	THRIV	E				Onset and De	eath
h	Examiner	_	Atherosclerotic C	ardiovas	scular Di	sease				
	xecuted and II-transit	Examiner	is any, leaving to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
8760	cate be executed obysician and the burial-transit	dical	d.							
O. Box 6	death certifi e attending I id for use as	Physician/Me		ctopic pregnancy Other (specify)			23d. Dat Mo	te of delive	,	ear
rds, P	requires that the de een signed by the a hould be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause give	n in Part I.		oacco use contres 2.21No	nbute to th		
Vital Records,	e law has b	Completed				24a. Was an autops perform	y ned?	Were autoporior to condeath?	osy findings av	vailable use of
Vita	icien: Sertific ector.	o Be C	25. Was case referred to medical examiner?	0	26. Place of Death	Check on on	в	_		
on of	nding Phys th. : After this of funeral directions	\vdash	1 Yes 2 No Nospital 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2 Accident 2 Accident Accident 2 Accident	28c. Injury Work	4 W Nursing Hon	ne 5 ☐ Reside 28d. Describe ho)	
Division	el or Atter s after dea il Director id in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	t, factory, office	2	28f. Location (St. City or Town		er or Rural	Route Number	97,
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	edical	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occarring the control of the basis of examination and/or investigand manner stated.	ccurred at the time	e, date and place, a inion, death occurre	and due to the ca	use(s) and ma ate and place, a	nner as sta and due to	ited. the cause(s)	
ì	To t To t	Σ	29b. Signature and title of certifier	29c. License		29	Od. Date signed	(Month, E	lay, Year)	
•	" De		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin		63199.		1171	1007		
	Sta	0	Yogesh Vohra M.D. 614 Easternshore Dr	Salisbu	ry MD 21	804				
*	Registr		31. Date filed (Month Starp Year) 5 2005 32. Signature	uli						

State of Maryland / Department of Health and Mental Hygien 0 5State Registrar/MFND#8,10bperFh9/14/05,BWW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Dorthea Williamson-Childs Sep. 2005 6:42 pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1953 Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 579-72-9331 Sep. Washington, DC 6. Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23e or 28a-f show other treumetic event, the Neufical Evantiner must be notified at 1 XYes 2 No Director MD Prince George <u>Temple Hills</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3422 Brinkley Road 20748 death 1 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other then "naturel", or itel 1 Never Married 2 Married
3 Widowed 4 Divorced Specify Black 1 ☐ Yes 2 ☐ No 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Counselor Mental Disabled 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norwood F. Williamson Dora Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 slowtheat of Health and creent: If item 27 is 1 Anquanette Williamson/ Daughter 3666 22nd Street SE Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Dep riment of
Importent: If it
any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

`4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 9/15/05 Riverdale, MD Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th Street NW Washington, DC 20011 List only one cause on each line. 23a. Part1. Inter me disease shock, or reart failure. Approximate Interval Between Onset and Death Immediate ause (Final disease 1 condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 certificate be Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No Division of Vital Records, P.O. 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 🔼 ⊀ б 1 npatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Deatural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50454 ale miller 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arastoo Yazdani, 3-41 VES SPRING beongin AVE 31. Date filed (Month, Day, Year) 32#Registrar's Signature State 1 4 2005 Registrar

State

ARTHUR

31. Date filed (Month, Day, Year) SEP 1 4 2005

10+1

Registrar DHMH 17 Rev 1/2001 3416

plandwood Ct.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JR

39. Registrar's Signature

Woodward

29d, Date signed (Month, Day, Year)

September 11, 2003

State of Maryland / Department of Health and Mental Hygien 2005 31581 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month THOMAS EARL WHITTINGTON September .2005 /Medical 12, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 174 Chesapeake Mobile Court Hanover
If Under 1 Year If Under 24 Hrs. Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1X M 2□ F Director Yrs June 30, 577-44-6562 1930 Maryland Usual Residence of Decedent death with the Maryland 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is markad othar than "natural", or Items 23a or 28a-f shov other traumatic evant, the Medical Examinar must be traiting at Director 1 X Yes 2 No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 174 Chesapeake Mobile Court 21076 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 195 1 X Yes 2 □ No If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1952filed within 72 hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HO115 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) House College (1-4or 5+) 12 Engineer- PG County Court Local Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is markad of Richard Whittington Ida Mae Walker 19a. Informant's Name/Relationship (Type, Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21076 Marie Janet Whittington -174 Chesapeake Mobile Court, Hanover, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any injury or once. Fort Lincoln Cemetery 9/15/2005 Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Euperal Service # 4739 Baltimore Ave., Hyattsville, Maryland 20781 23a, Part J. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cars, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequate of Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? P 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death Check only one) examiner's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 🛣 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ September 13, 2005 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) GARL (N) PLANEED ROAD 4304 MOUNTAIN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 1 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PUSDERICK /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VORNE Ali 5. Social Security Number ear If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York Months 089-20-7180 1⊠M 2□F Days Hours Director 78 Dec. 16, 1926 New Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic evant, Ira Medical Evantiar must be notified at 10d. Inside City Limits MD Completed by Funeral Director Baltimore P Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 1 Stockmill Road Pages 1 and 2 should be filed within 72 hours after death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Private 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Fredeick Quelch, Sr. Janes Phips ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Quelch - Wife of Health itam 27 Stockmill Rd., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State ŏΞ 1y Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Evergreens Cemetery Sept. 16,2005 Brooklyn, NY ture of Funeral Service Licenses 22. Name and Address of Facility Cedar Hill Funeral Home Suitland, MD 20746 Penn Ave., 24a. Pa 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im edi le Cause (Final dis as or condition Priysician /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 Probably 4 □Unknown 1 Tyes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 Other: 1 🗌 Yes 1 (I) Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Man of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funaral D 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address

31. Date filed (Month, Day, ar's Signature

cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiepe [] [] 5 1 - Stata Ragistra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:20A. Whittington 09 0705 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Riverdale Crescent City Center If Under 24 Hrs. If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Year 09 23 09 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Hours Min Funeral Months 1 ☐ M 2 🖾 F Yrs. Roanoke, VA. Director 577-28-0649 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State ns 23s or 28e-1 show must be notified at 1X Yes 2 □ No Completed by Funeral Director Clinton Prince Georges 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 USA 8608 Shorthills Court Items 23g 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 7 is markad other then "naturel", or Iten traumatic event, Ir e Medical Extention filed within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) John Hopkins Home Health Aide 5th. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is markad of Ruth Lowrey 0 Landon Lowrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8608 Shorthills Ct. Clinton, MD. 20735 Germaine Myles/Granddaughter or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ò permit. Page Department of Importent: If eny injury or once. Harmony Memorial Park 9-14-05 Landover, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequênce of): Examiner burial-transit Due to (or as a consequence of): Box 68760 attending physician ician/Medical as the b esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year for in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a P.O. Physi 9 Tlinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 🎉 Unknown 1 ☐ Yes 2 ☐ No Atrial fibrillation, Dementia Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 27 Manner of Death Certification; 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 4 / Homicide 24 hours a EX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D48213 09-12-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashai, M.D. 4410 74th. Avenue Landover Hills, MD. 20784 . Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 5 2005

DHMH 17 Rev 1/2001

Registrar

			For State	State of Ma	aryland .	Depa	urtment of F	lealth and i	Mental Hy	giene	20	05	31	584
- 4-		- Sec. 44	Registrar 1. Decedent's Name (First, Middle,				imeate or	Death	2. Date of De	Heg. No.			3. Time o	
	Physici		Marv	_		T.7L _ 1			Month	Day		'ear		М
	/Medic Examin		4a. Facility Name (If not institution,	Regina give street and number)		Whela		r Location of Deat	JSeptembe h		County of	Death	5:30	Ρ
	LXdiffiii	ici	Southern Maryland	Hospital			Clintor				ince G		.1.	
F	uneral			6. Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da				ace (State of	or Foreign
	rector		579-26-3193	1 □ M 2 📆 🚪	30	Yrs.	Months Days	Hours Min.	November 1					
Pu	>		Usual Residence of Decedent 10a. State 10b. County		10c. City, T									
aryla	e ho	2		George's								10	0d. Inside C	ity Limits 2 √√ No
he M	Sea-f	ecto	10e. Street and Number	George S	rt. W	lashing	-			10 00				XX
th with	23a or	Funeral Director	506 Kerby Hill Ro	ad			10f. Zip Code 20744		Ì	-	izen of Wh USA	at Count	ryz	
er dea	Rems Cer Fig.	uner	11. Maritat Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.))-	14. Race - Black,	America White, e		
ours aft	Frani	by	1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	lf Yes, Give Year or Dates:	(D	1	☐ Yes ऋ॔॔॔ंर्रिYo	Specify:			Specify:	W	hite	
72 h	"natu	Completed	15. Decedent' (Specify only highest	s Education grade completed)	1	(Give	ent's Usual Occup	during most of wor	rking	16b. Ki	nd of Busi	ness/Ind	ustry	
Mithin F	than a man	g.	Elementary/Secondary (0-12)	College (1-4or 5			OO NOT use retired	•						
H peli	int, in	e Co	12 17. Father's Name (First, Middle, L	ast)		Plant	Assignment	18. Mother's Nar	ne (First, Middle		ephone Sumame)		any	
d be	ked o	To B	William Leo Col						herine Sai		,			
shoul	mar	-	19a. Informant's Name/Relationsh		1	9b. Mailin	g Address (Street				r Town, St	ate, Zip (Code)	
nd 2	27 is r tra		Colleen Whelan / D	aughter		512 Ke	erby Hill R	load Ft. Wa	shington,	Mary]	Land :	20744		
F F G	othe other		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of		Date		cation - Ci	ty or Tov	vn, State	
Page ment o	ant: If		1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Balti	more	National Ce	em 9/19/	2005	Balt	imore	e, MI).	
permit.	Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature a Puneral Service L	alse,	1		Name and Addre						e PA	
r *	物源		23a. Part Enter the disease, or on shock, or heart failure. List of	complications that caused	the death. D								Approximat	te
Phy	sician		Immediate Cause (Final disease or condition	one cause Coeaci in	() hal	Q EVI-T	WE HE	not Fa	ilvate				Interval Bet Onset and	
~ _/M	edical		resulting in death)	Due to (or as a	a consequen	e of):	100	401 /-1	11000			1	7 34W	4
⊏xa	miner	L	Sequentially list conditions,	b										
pet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequen	ce of):								
cate be executed	physician and the burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or as a	a consequenc	ce of):						_		
9 8	/sicial	dicail		d.										
tificat	as th													
\$ 6 E	attending p	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth		ath 3	Ectopic pregnancy	,		2	23d. Date o		у	
the dea	signed by the attendin d be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)				Month		Day [*]	Year
that	ned by deta	by Ph	Part II. Other significant condition	ns contributing to death bu	it not resultin	g in the un	derlying cause giv	en in Part I.	23e. Did t	obacco u	se contribi	ute to the	cause of c	death?
edure:	been sign		Alcherre	V DIJSAI	3				1 🗆 '	Yes 2[3 DIME 3	☐ Proba	bly 4 □l	Jnknown
law r	has be je 2 sh	Completed							24a. Was		24b. We	re autop	sy findings	available ause of
The	his certificate has I director, page 2	Con								rmed? 2 No	dea	th? Yes 2		
cian	ector,	Be	25. Was case referred to medicat examiner?	Hamitali a				26. Place of Dea	th (Check only o	nne)				
Phys	this aldir	2	1 Yes 2 No	Hospital: Inpatie		Outpatient		4 Nursing H	ome 5 Resi					
ding .	ector: After th by the funeral	盲	Natural 5 ☐ Pending		Year)	b. Time of Injury	28c. Injur Wor M 1	γaτ k? Yes 2 □ No	28d. Describe I	now injury	occurred			
Aften deat	ctor: y the	fica	3 Suicide 6 Could no	ot be	rv - At home	. farm. stre		163 2 110	28f. Location (Street and	d Number	or Rural	Route Num	her
s after	et Dire	Certification:	4 Homicide	building, etc	(Specify)		,,		City or Tox	vn, State))			
To the Hospital or Attending Physician: The law requires that the death certification of the death cer	To the Funerell completely filled	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and mann place, and	er as sta d due to t	ted. the cause(s	;)
To th withir	To th	Me	29b. Signature and title of certifier				29c. Licens	number		29d. Date	signed (/	Month, D	ay, Year)	
/			1/8					7431		7/1	3/05			
2 (4	5)		30. Name and address of person w	the completed cause of de	eath (Item 23	a) (Type, I	Print)	18 FT	Winher.	a fo	15)).	Did	
5. S.	% Sta	te	31. Date filed (Month, Day, Yeal)	32. Registra	r's Signature	751	0 /09.	.03 //	- Aller	4100		- 4	11-17	
	Registr		SEP 1 5 20	105 Kedur	K	free	1							

DHMH 17 Rev 1/2001

	•		1- State of Maryland / Depa Registrar Cer	artment of Health and Mertificate of Death	ental Hygie	2005	31585
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death - Month	Day Year	3. Time of Death
	/Medic	al .	Claudie Atkins 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	4c. County of Deat	
	Examin	er	Anne Arundel Medical Center	Annapolis		Anne Aru	
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birt	hplace (State or Foreign
	Director		252-96-0357		Aug 25, 1	1952 Atl	cinson
	yland yland		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
	Ba-f s	Director	MD Prince George's Bowie	2			1 ☐ Yes 2 ☐ No
	with the		15311 Pine Tree Way	10f. Zip Code 20721		. Citizen of What Co JSA	ountry?
	ms 23	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Spec	city Yes or No-	14. Race - Ame	rican Indian,
9	or ita	/ Fur	Armed Forces?	f Yes, specify Cuban, Mexican, Puerto F 1□ Yes 2⊠ No Specify:	Rican, etc.)	Black, White	
9	hours turai',	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1.0		Lack
7	n na	Completed	(Specify only highest grade completed) (Give life. L	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	9	b. Kind of Business/	industry
212	ad with	Com		nine Operator	I	umber	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Itams 23a or 28a-f show aumatic event, the Medical Eventime Final Le Indiffied at	Be	17. Father's Name (First, Middle, Last) Charlie Atkins	18. Mother's Name Lillian S			
<u> </u>	should nd Mer marke matic	은		ng Address (Street and Number or Rural			Zin Code)
S	alth ar 27 is			Bll Pine Tree Way B		-	
altimore,	es 1 a of Hea fitam rothe		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposicemetery, crem	sition (Name of Danatory or other place)	ate 20	c. Location - City or	Town, State
Ē	Pag tment tant: I		`4 Donation 5 Other (Specify) Lenox Cem		-05	Lenox, GA	<u> </u>
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic eage.		1 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Name and Address of Facility Lane Memorial Chape	1		
		7	23a. Part . Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	15 MLK Drive Adel or the mode of dying, such as cardiac or			Approximate
	Physician			lostate conse	0		Interval Between Onset and Death
Н	/Medical Examiner		resulting in death) Due (0 (or as a consequence of):	1			3 12 41
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	lue			20146
X	outed nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
8760,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):				
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	d				
Box (eath certific attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
	e death he atte	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
P.0	res that the de signed by the a l be detached t	Physi	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I	23e. Did tobac	co use contribute to	the cause of death?
Records,	quires n sign	d by			1 ☐ Yes	2 1 9 3 Pr	obably 4 Unknown
000	aw require ts been sig 2 should b	Completed			24a. Was an	24b. Were au	topsy findings available
		Com			autopsy performed 1 Yes 2	d? death? 1 ☐ Yes	completion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
	Phys this ral di): To	1 Yes 2 FR/Outpatient 2 ER/Outpatient 27. Manner of Dorth 28a, Date of Injury 28b, Time of		e 5 Residenc		pify)
Division of	Attanding For death. actor: After by the funer.	atior	1	Work? M 1 ☐ Yes 2 ☐ No			
<u>S</u>	or Atta ter de irecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	3f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Ω	pital cours af aral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	a conversed at the time, date and place as	ad due to the eque		atotad
	To the Hospital or Attank within 24 hours after death To the Funaral Director: completely filled in by the	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occurred	d at the time, date	and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certified	29c. License number	29d.	Date signed (Month	n, Day, Year)
	/		M Wol	77437 476		1/92/10	07
	b	7.5	30. Name and address of person who completed cause of death (Item 33a) (Type, F	Print Mula Mala	of ca	der	
150°	∜ Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	٧.			
	Registr	ar	SEP 2 9 2005				

			State of Maryland / Department of Health and Mental Hygierre 05 3 1 5 8 6 Certificate of Death Reg. No.
	Physici /Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1:07 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. Source of Death 4c. Source of Death 4c. Source of Death 4c. County of Death 4c. Source o
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 M 2 Dec State or Foreign Nonths Days Hours Min. Nonth, Day, Year) Would Residence of Decedent 7. Age (In yrs. last birthday) 1 M 2 Dec State or Foreign Country) 9. Birthplace (State or Foreign Country) Figure 1 Figure 2 Figure 3 Figure 3 Figure 3 Figure 4 Figure 4 Figure 4 Figure 5 Figure 5 Figure 5 Figure 5 Figure 5 Figure 6 F
	a-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits HD Baltimore Abing don 10p. County 10p. City, Town or Location 10p. County 10p. County 10p. County 10p. City Limits 10p. County 10p. C
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1209 Hidden Stream Ct. 10f. Zip Code 10g. Citizen of What Country? USA
920	72 hours after death with the Maryland naturel', or Itams 23e or 28e-f show dical Examinet must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Do If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes 2 DNo Specify: Will Life.
21215-0036	d within 72 hours jiene. r than "natural", Ir e Madic: E.u	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
	ba filed Ital Hyg Id otha svant,	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	and Nand Is mar	To	Michael StarRoDoulou ASDASIA UNKNOWN 1992 Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	ges 1 and t of Healt if itam 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore,	permit. Pag Department Important: any injury enge.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton-T-uneeal Home, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic CARdio VASCULAR disease Pen years Due to (or as a consequence of):
10	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
8760,	icate be exe physician a s the burial-	icai	Due to (or as a consequence of): d.
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown 9 1 1 1 1 1 1 1 1 1
ds, P.	uires that signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown
Records,	The law requir ate has been s page 2 should	Completed	24a. Was an autopsy autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vita		o Be	25. Was case referred to medical axaminer? 1 Yes 2 No
ion of	Attending Physician: r death. sctor: After this certific by the funeral director,	ation: T	27. Manner of Death 1 S Natural 5 Pending 2 □ Accident investigation 28a. Date of Injury 28b. Time of Injury 38b. Time of North, Day Year)
Division	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours after to the Funaral Dir.	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	with Tot	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
	/		Makk Wild and Revision of person who completed cause of death (Item 23a) (Type, Print) MAKK Wild and RVENUE BEL AIR MARYLAND 21014
	Sta Registi	rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 9 ZUU5
DH	MH 17 Rev 1/2	001	ORIGINAL

	1 - For State Registrar					tificate of	Health and I <i>Death</i>		Reg. No	~ ~ ~ ~	- 0150		
	1. Decedent's Name (F	irst, Middle, Las	st)					2. Date of D	eath	200	'9' Tine Duth		
an al	Patrio	cia M.	. Andre	ws				Sept.	. 22	2°200°5°	7:25p		
er	4a. Facility Name (If no	t institution, give	street and number)			4b. City, Town,	or Location of Deat			c. County of De			
	Frankl	in Wood	ds Cente:	r		Rose	edale		}	Balti	more		
	5. Social Security Num 220-20-38	308 1	9x	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D Sept.			Birthplace (State or Forei Country) Maryland		
	Usual Residence of De	b. County		10c. City, To	own or Loc	cation					10d. Inside City Limi		
ō	MD I	Baltimo	ore	,,,,,		ddle Ri	vor				1 🗆 Yes 2 🛣		
Director	10e. Street and Number					10f. Zip Code			10a C	itizen of What	Country?		
Ö	3811 F	Dunsi	nuir Ciro	cle		21220)		US		Country .		
runerai	11. Marital Status	- Julion	12. Was Decedent	Ever in U.S.	13. W			pecify Yes or N			merican Indian.		
2	1 Never Married 3 Widowed 4		Armed Forces? 1 ☐ Yes 2 ☑! If Yes, Give Year or Dates:		1	Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puerl Specify:	o Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
tea	, 15	. Decedent's Ed	lucation	16	Sa. Decede	lent's Usual Occu	pation		16b. H	Kind of Busine	ss/Industry		
Completed	(Specify Elementary/Seconda	only highest gra	de completed) College (1-4or 5	E.)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			rking			•		
200	12th	, \/	23.10g0 (1.401 c	, H	omer	maker ———			OW	n hom	e		
Bec	17. Father's Name (Fire						18. Mother's Nar			n Sumame)			
2		e Kelle	_ -				Mildr	ed Bur	ns				
	19a. Informant's Name			15			and Number or Ru		-				
	Richard	Andrev	vs /son				Arbor D	rive E	Balt	imore	MD		
	1 ☐ Buriai 2 🔯 C	20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Baltimore MD											
	D-T	Service Licen	see	00	22.	. Name and Addre	ess of Facility Co	nnelly	Fun	eralH	omeofEsse		
	23a. Part1. Enter the c shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	disease, or dilure. List on li	Slications that caused one cause on each line	locar	not ente	_ 300 N	lace Ave	. Balt	imo	eralHore MD	OmeofEsse. 21221 Approximate Interval Between Onset and Death		
licai Examiner	Immediate Cause (Fin	disease, or nilure. List on al	Due to (or as	a consequence a consequence a consequence a consequence	not ente	_ 300 N	nace Ave	. Balt	imo arrest,	eralHore MD	21221 Approximate Interval Between		
Examin	Immediate Cause (Fin disease or condition resulting in death) fi any, leading to imme cause. Enter Underlyii Cause (Disease or injutat initiated events	disease, or dividure. List on al diate ag ry	Due to (or as	a consequence a consequence a consequence a consequence The consequence a consequence	not ente	300 Mer the mode of dyi	Mace Aveng, such as cardiac of farct of Di	e. Balt cor respiratory a	imo arrest,	eralHore MD	Approximate Interval Between Onset and Death		
by Physician/Medicai Examin	Immediate Cause (Findisease or condition resulting in death) Security list nondification of any, leading to immediate. Enter Underlying Cause (Disease or injuthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent print he past 12 mointhe past 12	disease, or dividure. List on all diate agreement all egnant of the control of th	Due to (or as b. Due to (or as d. Due to	a consequence a consequence a consequence a consequence a consequence a consequence a consequence b description a consequence a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description b	not ente	Arte Meu Ston Ectopic pregnanci Other (specify)	Mace Aveng, such as cardiace Tharct Tharct Little	Sea X	zimo	23d. Date of commonth	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death Death Death Death Dea		
by Physician/Medicai Examin	Immediate Cause (Findisease or condition resulting in death) Schemics in death) Finding in death (Findisease Cause, Enter Underly) Cause (Disease or injuthat initiated events resulting in death) Las IF FEMALE: 23b. Was decedent print the past 12 months of the p	disease, or dividure. List on all diate agreement all egnant of the control of th	Due to (or as b. Due to (or as d. Due to	a consequence a consequence a consequence a consequence a consequence a consequence a consequence b description a consequence a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description b	not ente	Arte Meu Ston Ectopic pregnanci Other (specify)	Mace Aveng, such as cardiace Tharct Tharct Little	239. Did	tobacco Yes 2	23d. Date of or Month use contribute No 3 24b. Were	Approximate Interval Between Onset and Death Death Onset and D		
by Physician/Medical Examin	Immediate Cause (Findisease or condition resulting in death) Schemics in death) Finding in death (Findisease Cause, Enter Underly) Cause (Disease or injuthat initiated events resulting in death) Las IF FEMALE: 23b. Was decedent print the past 12 months of the p	disease, or dividure. List on all diate agreement all egnant of the control of th	Due to (or as b. Due to (or as d. Due to	a consequence a consequence a consequence a consequence a consequence a consequence a consequence b description a consequence a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description b	not ente	Arte Meu Ston Ectopic pregnanci Other (specify)	Mace Aveng, such as cardiace Tharct Tharct Little	239. Did	tobacco Yes 2	23d. Date of commonth use contribute 2 No 3 24b. Were prior to death	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O		
Completed by Physician/Medical Examin	Immediate Cause (Findisease or condition resulting in death) Security is not if any, leading to imme cause. Enter Underlyi Cause (Disease or injutati mitated events resulting in death) Last IF FEMALE: 23b. Was decedent print the past 12 month of the past 12	disease, or dilure. List on di	Due to (or as b. Due to (or as d. Due to	a consequence a consequence a consequence a consequence a consequence a consequence a consequence b description a consequence a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description a consequence b description b	not ente	Arte Meu Ston Ectopic pregnanci Other (specify)	Pace Aveng, such as cardiace for the farct of the farct o	239. Did 24a. Was auto	tobacco Yes 2 s an psy ormed? 2 No	23d. Date of commonth use contribute 2 No 3 24b. Were prior to death	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O		
o Be Completed by Physician/Medical Examin	Immediate Cause (Findisease or condition resulting in death) Schemics in death) Finding in death in any, leading to imme cause. Enter Underlying Cause (Disease or injuthat initiated events resulting in death) Las IF FEMALE: 23b. Was decedent pring the past 12 months of the past 12	disease, or dilure. List on di	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence a	not ente	300 Mer the mode of dying and dying and dyin	Pace Aveng, such as cardiac farct Di Di Land	23e. Did 23e. Did 24a. Wate perf	tobacco Yes 2 s an psy ormed? 2 No	23d. Date of c Month use contribute CNo 3 24b. Were prior t death 1 Y	Approximate Interval Between Onset and Death Death Onset and D		
To Be Completed by Physician/Medical Examin	Immediate Cause (Findisease or condition resulting in death) Security is not if any, leading to imme cause. Enter Underlyi Cause (Disease or injuthat initiated events resulting in death) Last 12 mo 1	disease, or diseas	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence a	not ente	300 Mer the mode of dying and the mode of dying and the mode of dying and the mode of dying and the mode of dying and and and and the mode of dying and and and and and and and and and and	Place Aveng, such as cardiace from the cardiace	239. Did 24a. Was auto	tobacco Yes 2 san psy ormed? 2 No one) idence	23d. Date of commonth use contribute Commonth 24b. Were prior to death 1 1 4	Approximate Interval Between Onset and Death Death Onset and Death Death Death Death Death Death Death Death Death Death Death		
o Be Completed by Physician/Medical Examin	Immediate Cause (Findisease or condition resulting in death) Security is not if any, leading to imme cause. Enter Underlyi Cause (Disease or injuthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent print the past 12 mon 1	isease, or dilure. List on all interest	Due to (or a) Due to (or a)	a consequence a	not ente	300 Mer the mode of dying and the mode of dying and the mode of dying and the mode of dying and the mode of dying and and and and the mode of dying and and and and and and and and and and	Pace Aveng, such as cardiace for the such as c	23e. Did 23e. Did 1 24a. Was auto perf. 1 Yes 28d. Describe	tobacco Yes 2 san psy ormed? 2 No one) idence how inju	23d. Date of common Month use contribute No 3 = 24b. Were prior to death 1 = You 6 = Other (Sp. iny occurred)	Approximate Interval Between Onset and Death delivery Day Year to the cause of death? Probably 4 Munknow autopsy findings availab o completion of cause of ease 2 No		

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

1124 Mace Ave Dairo, MD 21221

31. Date filed (Month, Day, Year)

38. Registrar's Signature

SEP 2 9 2005

ADH CARROLL BRADFORD 05-6559

-6559		1- Stata Amend Item 20 Registrar Unpend Item	Ob ^{State} of Marylar	ndy_Dep	utmen 55. Ea	t of Health and	Mental Hygi	ene 2 0 0	5 21500
	10	Registrar Unpend Iter 1. Decedent's Name (First, Middle, La.	n 23a&27 per m	e G848/	tificat	e of Death 10			5 31588
Physicia		CARROLL		Bo	AA	FORD	2. Date of Death Month SEPTEMBE	R^{Day} 26, 200	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	- O/4		Town, or Location of De		4c. County of Di	
		1216 CAROLINE STR				IMORE CITY			NIA
Funeral Director		5. Social Security Number 6. S 217-40-6182 1 Usuat Residence of Decedent	ex 7. Age (In yrs.	2 Yrs.	If Under Months	1 Year If Under 24 H Days Hours M		ear Cullo	Birthplace (State or Foreign Country) 1 ARYLAND
d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene, they free then *natural; or items 23s or 28s-1 ehow int, the Medical Examinar must be notified at	_	10a. State 10b. County		ty, Town or Lo	cation			~	10d. Inside City Limits
the M 28a-f	Director	MARY/AND 10e. Street and Number	NIA		X	DALTIN	MORE (LITY	1 🖟 es 2 □ No
h with		1216 N. C	AROLIVE	ST	10f. Zip	2 13	2/3	g. Citizen of What	Country?
r deal	Funerai	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V	Vas Deced	ent of Hispanic Origin? rfy Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ar	merican Indian,
36 rs afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates;		☐ Yes 2		orto ritoari, etc.)	Black, W	hite, etc.
15-0036		15. Decedent's Ed	ucation	16a. Deced	ent's Usua	Occupation	1 10	6b. Kind of Busines	BLACK
and 21215-0 be filed within 72 ho tial Hygiene d other then "netur event, the Medical	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of wor OO NOT us	k done during most of w e retired)	vorking	o. Kind of Busines	Samuustry
d 21, Hilled with Hygiene, ther the		9 THGRADE 17. Father's Name (First, Middle, Last)		L.	TND	SCAPINO		ACKS LA	NOSCAPING CO.
lan	To Be		LMER X	BRAD	FOO		ame (First, Middle, Ma	iden Sumame) EU	
S sho		19a. Informant's Name/Relationship (7				(Street and Number or	SUral Route Number, (
≥ 5 € Z ;		OLIVIA B. THOP		340	7 78	RESACO	WRT, BI	ALTIHORE	MD. 21213
O 8.2 = 5		20a. Method of Disposition 1. △Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispos semetery, crem	atory or ot	e of	-4-05	c. Location - City	r Town, State
Baltim permit. Pag Department Important: eny injury o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Septile Licen				EME . 07	04-05 L		WNE, MD
Baft permit. Departimont Import eny inj once.		House	ons	2	19,5	EPH H.	BROWN	B. FUNE	MD. 21217
		3a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	h. Do not ente	r the mode	of dying, such as card	ac or respiratory arres	JAZIO,	Approximate Interval Between
Physician		tmmediate Cause (Final disease or condition resulting in death)	_a Arteriosclero	tic ca	rdiov	ascular dis	sease		Onset and Death
/Medical Examiner		(Southing an obatin)	Due to (or as a conseq	uence of):					
	Je.	Sequentially list conditions, if any leading to infinite cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a conseq	uanes of):					
60, A be executed be executed burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.						
		resulting in death) Last	Due to (or as a consequ	uence of):					
	edicai		d. ==						
Records, P.O. Box 6: The law requires that the death certific te has been signed by the attending p age 2 should be deteched for use as:	by Physician/M	zas. Tras accodent program	23c. If yes, outcome of pregna 1□Live birth 2□Fetal					23d. Date of d	alivery
the dee	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de		Ectopic pre Other (spe			Month	Day Year
P.O. that the ded by the deteched	e l	Part II. Other significant conditions co		ulting in the un	docking on	von enven in Dent I	On Diday	1	
Vital Records, Pasician: The law requires the certificate has been signed trector, page 2 should be det	D D		The state of the s	21.0119 111 1110 1111	ourlying ca	use given in Part I.			to the cause of death? Probably 4 Unknown
ecord	Completed						24a. Was an		utopsy findings available
	E						autopsy performe	prior to death?	completion of cause of
of Vital Physician: The this certificate at director, page	e E	25. Was case referred to medical examiner?	To a relati				1 Yes 2 eath Check only one	10 10	s 2□ No
- 5 SD	0	1 ② Yes 2 No 27. Manner of Death		ER/Outpatient			Home 5 ☐ Residence		ecify) SCENE
ion nding ath. r: Afte	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M 28	c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred	
Division or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory,		28f. Location (Stree	t and Number or F	Bural Route Number,
Ditel o urs aff							City or Town, S	•	
Division o To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1☐ Certifying Phy 2☒ Madical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death i ion and/or inve	occurred at estigation, i	the time, date and place n my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner a and ptace, and du	s stated. e to the cause(s)
To the To the Comple	Z e	29b. Signature and title of certifier	and mainter stated.			License number		Date signed (Mon	
12.8.		Y & Jarle	MAD		(OCME		PTEMBER 2	
Book		30. Name and address of person who co	ompleted cause of death (Item		•				
Opi	1	31. Date filed (Month, Day, Year)			N STRI	EET, BALTIM	ORE, MARYLA	ND, 21201	
State		31. Date filed (Month, Day, Year) SEP 2 9 20	32. Registrar's Signat	ura 🧀					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** AARON I. BOYER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Yrs. 366-07-0958 Director 94 Aug 1, 1911 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location I7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar maint be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 427 Yellow Springs South 20724 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

Wayes 2 No 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo þ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Gov't Printing Office Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Book Binder Federal Government permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Boyer Lillian Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Boyer spouse 427 Yellow Springs South Laurel, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 09/30/2005 Cheltenham, Maryland 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) exempovascular acrident **Physician** 6 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has tirector, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Oulpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48213 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) landovertille MD 20784 Neelaw Ashai 4410 74th Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year BYNUM IERMAN SEPTEMBER 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOUR BALTIMORE HOSPITAL NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F 239.30.5061 83 Director Yrs. 12.12.1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 KYes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 WHITMORE AVENUE 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: BLACK ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Itam 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) CARETAKER HOSPITAL 12 TH GRADE NA 17. Father's Name (First, Middle, Last) LUK 18. Mother's Name (First, Middle, Maiden Surname) VINNIE WALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON STEVIE BYNUM 918 WHITMORE AVE., BALTO. MD 21216 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 09.30.05 CROWNSVILLE ^¹ 4 □ Donation 5 □ Other (Specify) CROWNSVILLE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE ang/ 5151 BALDO. NATU PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (i.r. s a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (s a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached to 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 ☐ Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. MVEL 413 commanwealth Ai 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State SEP 2 9 2005 Registrar

			State of Maryland / Department of Health and Mental Hygieme 05 3 159 1 - State Registrar Certificate of Death Reg. No.	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	
	Physici /Medic		Hezekiah Edward Bradds 9 27 2005 7:45 x	М
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			5. Social Security Number 6. Sex Mage (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore)	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7 Age (In yrs. last birthday) 7 Yrs. 1 Months Days Hours Min. 7 Age (In yrs. last birthday) 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8 - 19 - 1929 9. Birthplace (State or Forei	gn
	D		Usual Residence of Decedent	
	ehow	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi	
	he M	ecto	10e. Street and Number 10g. Citizen of What Country?	
	with Sa or	i Dir	107 S. Stricker St 21223 USA	
	death ms 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	_
98	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28a-f ehow or other treumatic event, the Medical Exercited round be notified at		Armed Forces? If Yes, specify Cuban, Mexican, Puerro Rican, etc.) Black, White, etc. I ☐ Yes, 2 ☐ No Specify: Specify: () \	
21215-0036	hours tural;	ed by	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
15	n na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	
21	filed within Hygiene. Ither than ont, the Max	mo:	Labor Labor	
nd	be file	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	should be and Mental is marked c	၉	19a. Informar Name/Relationship (Type, Print) , 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ma	and 2 s ealth an n 27 is i		Teresa Johnson Dante P.O. Box 603 Fruitland, MD 21826	
re,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	\neg
imo	Pa anti-		1 Burial 2 Defendation 3 Removal from State Commentary, Control of Other place) 4 Donation 5 Other (Specify) Commentary of Other place) 9 - 29-05 By 140. MD	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service (Icensee) 22. Name and Address of acility (3, 1/2 (11) 2, 224	
	40 E # 0		Monde Kely Cremation Services 515, B4 HON-HP.Ke	
	25 25		23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Immediate Cause (Final	
	Pnysician /Medical		disease or condition resulting in death) Due to (_rat a consequence of):	_
Е	Examiner			
1	₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Entire Unidentifying Cause (Disease or injury) b. Cent Well Due to (or as a consequence of): Hy Dry Mornis (Disease)	
k	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
8760,	be ex ician burial		Due to (or as a consequence or):	
687		edicai	d	
Вох	death certifi e attending p id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery	
.O.	0 0 0	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 Other (specify)	
۵.	res that the de signed by the a be detached t		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Records,	- v -	ed by	Chronic Obstructive Luzy Cisense 10 10 20 No 3 Probably 4 Dunknow	m
000	aw requis been 2 shoull	Completed	CANTAL AVIATHMIN ROLLING 24a. Was an 24b. Were autopsy findings available	
- Re		Com	autopsy performed death? The second of the completion of cause of the cause of the completion of the cause of the completion of the cause of th	
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	
of	Phys this ral dii	. To	1 Yes 2 No Hospital: Vinpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Magner of Death 28a. Die of Injury. 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
on	nding Ph th. : After th funeral	ition	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
Division	Attancer death	Certification:	Suicide Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) City or Town, State)	
O	rs after rs after rel Dir led in	Cert	Surang, die. (Specify)	
	To the Hospitei or Attanding within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the vithin To the Comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			Jatram Hall M 20475 9 9127105	
	3		30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) ANTHUM TOSENIA 1940 W. RMA ST RMA MD 21227	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Registi		SEP 2 9 2005 Mayor It Appell	

State of Maryland / Department of Health and Mental Hygien 0051 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** September 28,2005 VIRGINIA M BENNETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARFORD -ORIED KIURSIde If Under 2/ Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 M 2000 219-28-7402 75 Yrs. Director MARYLAND 11 1930 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examinar must be notified a 1 ☐ Yes 2√ No Director MARYLAND HARFORD CO ABERDEEN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 CLAYTON STREET 21001 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Nidowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: In and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) N/A 8th grade HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ EDWARD W GRIFFITH BERTHA M GRIFFITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health ar Robert G. Bennett/Son 703 Clayton St., Aberdeen, Md., 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) BEL AIR MEMORIAL 10-01-05 BELAIR, MARYLAND 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD P, A. seower S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the configuration of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): Box 68760, the attending physician hed for use as the burial The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12v 1 Yes 2 Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant condi ions contributing to death but not registing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 Ne 1 Tes ¬ 3 □ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be Place of Death (Check only one) Other Certification; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 27. Ma 28a. Date of Injury (Month, Day Year) ne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending latural 1 Yes 2 No after death ☐ Accident investigation the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License numb 29b. Signature 29d. Pate signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co B LINDIA FREILICH 31. Date filed (Mont 32. Registrar's Signature 9 2005 State Registrar

		For	State of Marylan						01500
		1 - State Registrar		Cer	tificate of	Death		<u>2005</u>	31593
Physici		1. Decedent's Name (First, Middle, Last) John H. Buck1	er				2. Date of Death Month Sep. 26	Day 2005 Year	3. Time of Death 7:00P M
/Medic Examin		4a. Facility Name (If not institution, give s.			4b. City, Town, o	or Location of Deat		4c. County of Death	1
- LAGITITI		Future Care Cl	herrywood		Reis	stersto	√n	Baltim	ore
Funeral Director		263-30-4887	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,) July 15	(ear) 9. Birth Cou	nplace (State or Foreign untry) ryland
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Mary Ff sh	tor	MD Baltime	ore R	eiste	rstown				1 ☐ Yes XXNo
th the	irec	10e. Street and Number			10f. Zip Code		100	. Citizen of What Cou	untry?
ath wi	rai	300 Cantata Co				1136		U.S.A.	•
er des Itams	by Funeral Director	11. Marital Status 1 ☐ Never Married ※X Married	 Was Decedent Ever in U. Armed Forces? XXYes 2 □ No WW I 	S. 13. V	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
urs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Kore		1□Yes 🏋 🏋 No	Specify:		Specify: W	hite
if e), Mally fall of 2.12.1.3-00.30 s. 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deceo	ient's Usual Occup	pation	16	6b. Kind of Business/I	ndustry
ithin "il	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)	i		
filed withi Hygiene. other therent, the M		17. Father's Name (First, Middle, Last)	2	Qu	lality	Enginee	ne (First, Middle, Ma	Manufact	uring
yidiliU ould be file Mental Hy arkad oth	o Be	Howard F. Buc	k1or				v O. McS		
2 should and Me is mark	ဥ	19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address (Street			City or Town, State, Zi	ip Code)
tand 2 Health a		Josephine W. Buc	kler/Wife					erstown,	
es 1 a of He rother		20a. Method of Disposition XI XI XI XI XI XI XI XI	20b. P	lace of Dispo	sition (Name of natory or other pla W	ce)	Date 20	c. Location - City or T	own, State
Page ment ent: th ury o		'4 □Donation 8 □Other (Specify)	Mem	crial	Park	9/	30/05	Sykesvill	Le, MD
partitions permit. Pages 1 Department of H Important: if Its any injury or ot		21. Signature of Funeral Solvice License		The second second					napel P.A.
		23a. Part1. Enter the disease, or complic	entions that sourced the death						Approximate
Physician /Medical Examiner		shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	shalo	,				Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
ufficate ig phy as the									
LIVISION OF VIGAL NECOLAS, F.C. BOX 50 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliv Month	very Day Year
that the post of the details		Part II. Other significant conditions con-	tributing to death but not resu	alting in the un	nderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
w requires to been signed should be o	ed by	Dysphagia					1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Hunknown
YILAI NECO! Ysician: The law request certificate has been director, page 2 shoul	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
VICIAN: I	Be	25. Was case referred to medical examiner?	ospital:	_	104		th (Check only one)		
Physic this cral dir	. To	1 Yes 2 No	1 Inpatient 2 2	ER/Outpatient 28b. Time of	t 3 DOA		ome 5 Resident	ce 6 □Other (Speci	f(y)
ding h.	tion	1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □No	28d. Describe now	milary occurred	
UNISION at or Attending s after death. I Diractor: After id in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Stree City or Town,	et and Number or Rur State)	al Route Number,				
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
To ti Withii To ti comp	ž	29b. Signature and title of certifier	3-0.7+		29c. Licens			. Date signed (Month,	
0,		► Maren L f	Jackett, MI)	· = = =	Doc	28676	56	ptember	77, 2005
10		30. Name and address of person who con Varen L. Bab + t 31. Date filed (Month, Day, Year) SEP 2 9 20	mpleted cause of death (Item	23a) (Type, I	Print)				
Sta Registr		SEP 2 9 20	32. Registrar's Signa	D. A.	orași		<i>‡</i>		

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	oartmen ertificate			nental Hy	ygiene		31594				
			Decedent's Name (First, Middle, L.	ast)					2. Date of D	eath		3. Time of Death				
	Physicia		Emalew		В	owers			Sept.	Day 2		2:49 PM				
	/Medic Examin		4a. Facility Name (If not institution, g.	ive street and number)			Town, or Lo	cation of Death			County of Death					
			12300 Rosslare R	idae Rd #	201	Ti	moniu	m		В	altimore					
	Funeral		5. Social Security Number 6.	Sex /. Ag	e (In yrs. last birthda)		1 Year If	Under 24 Hrs. Hours Min.	8. Date of B			place (State or Foreign intry)				
	Director		217-28-5946	1 M 2 F	73 Yrs.	IVIOLITIES	Days	10073	Nov.	28 1	931 N	Y				
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits				
	eho.	5	771 = 1									1 Yes 2 No				
	Ne M	Director	MD Baltimo	re	Timo	nium	0.11			40 00						
	with t	급		idea Dal #	201	10f. Zip					izen of What Cou	intry?				
	n 72 hours after death with the Maryland "natural", or Items 23e or 28s-f ehow edical Evanurat must be codified at	Funeral	12300Rosslare R	12. Was Decedent		Was Deced		1093	acify Vac or N		USA 14. Race - Ameri	ican Indian				
_	Item Item	Ľ.	1 Never Married 2 Married	Armed Forces?		If Yes, spec	of Cuban, I	anic Origin? (Sp Mexican, Puerto	Rican, etc.)	10-	Black, White					
2	irs af	by	3 November 4 Divorced	If Yes, Give		1 ☐ Yes 2	ZIXNO S	Specify:			Specify: W	hite				
2-0020	72 hours after natural', or Ite	ted	15. Decedent's			edent's Usua				16b. Ki	nd of Business/Ir	ndustry				
20	within 7; iene. then "n	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	life	e kind of wor DO NOT us	k done duri e retired)	ng most of work	king							
7	d with	Completed	cionistiaty/occordary (o-12)	4		memak	er			0	wn Hom	e				
aud	othe othe	Be C	17. Father's Name (First, Middle, Las	st)			18	Mother's Nam	e (First, Middle							
	uld b Venta Irked Itlc e	10	Clyde Lashorne	Downs				Mart	ha Hay	nes						
a	2 sho and 1 is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address	(Street and	Number or Rui	ral Route Numi	ber, City o	r Town, State, Zi	p Code)				
2	iit. Peges 1 and 2 should artment of Heelth and Mer ortant: If Item 27 is marks injury or other traumatic		Stuart Bowers/S	tep-Son				Road, C	wings 1	Mills	, MD 2	1117				
9	of He	- 1	20a. Method of Disposition 1 ☐ Burial 2 ②*Cremation 3	□ Bamoual from State	20b. Place of Disp cemetery, cr	position (Name	ne of ther place)		Date	20c. Lo	cation - City or T	own, State				
aitimor	nat. Peges partment of cortant: If it		*4 □ Donation 5 □ Other (Spec		National	Crema	torv	9/26	/05	Fall	s Churc	h. VA				
ä	Departr Departr Importa any injudence		21. Signature of Funeral Souther (Specify) National Crematory 9/26/05 Falls Church, VA 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093													
ם	8258		Michael J. F	Yagle		10 W.	Pado	nia Rd.	, Timo	nium	, MD 21	093 Thc.				
			23a. Part 1. The disease, of shock, or heart failure. List only	plications that caused y one cause an each lin	the death. Do not e	nter the mode	of dying, s	uch as cardiac	or respitatory	arrest,		Approximate Interval Between				
	Physician	shock, or heart failure. List only one cause in each line. Immediate Cause (Final														
	/Medical		disease or condition resulting in death) a. Due to a ras a consequence of):													
	Examiner		I CAYLAND ALL (STABLE)													
100		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
×	nd trans	Examine	that initiated events	c					/							
5	e exe ien a urial-	Ä	resulting in death) Last	Due to (or as	a consequence of):											
0/0	ate b hysic the b	lical		d												
Ď	that the death certificate be executed ed by the attending physicien and detached for use as the buriat-transit		IF FEMALE:													
Z OZ	death co	Physician/Me	23b. Was decedent pregnant in the past 12 reports?		2 Fetal death 3	□Ectopic pre				1	23d. Date of deliv Month	ery Day Year				
- -	the a	slc	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (spe	ecrty)					54)				
Z.	that the ed by the detache		Part II. Other significant conditions	contribution to death h	ut not resulting in the	underhing ca	use gwee i	o Part I	23a Did	tobaccou	se contribute lo t	the cause of death?				
Š	w requires that s been signed b should be deta	þ	Tutti. otto olganooni ootto	contributing to double b	at the resulting in the	underlying co	iuse giveirii	ir carti.	10		No 3 Prol	•				
spiooa	requires seen sign hould be	Completed							7	0 1		Dably 4 Olikilowii				
ည	a law	nple							24a. Was	ppsy	prior to co	opsy findings available ompletion of cause of				
=	: The l	S							1 ☐ Yes	orned?	death?	2 □ No				
N I G	ysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			1 -	B. Place of Deat	h Check on	one						
5	Physician: this certific ral director,	5	1 ☐ Yes 2 No	1linpatie	nt 2 ER/Outpatio			4 Nursing Ho			Other (Special	fy)				
<u></u>	ing F	Certification:	27. Manuer of Death 1 Statural 5 ☐ Pending	28a. Date of Inju (Month, Date	y Year) 28b. Time Injury		Bc. Injury at Work?	0 EN-	28d. Describe	how injur	y occurred					
VISION	r Attending er death. rector: After by the funer	cat	Accident investigati 3 ☐ Suicide 6 ☐ Could not	ho		М	_	2 🗆 No	ent I :							
⋛	or Al	E	4 Homicide determine		ury - At home, farm, s c. (Specify)	treet, factory.	, office			(Street and wn, State,		al Route Number,				
_	pital		20a Carifica Designing S	Physician To the best												
	Hos 24 ho Fun stely t	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	Physician: To the best of miner: On the basis of and manner sta	examination and/or	am occurred a investigation,	in my opinio	date and place, on, death occur	and due to the red at the time.	cause(s) , date and	place, and due to	o the cause(s)				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	2110 111011101 5(8		29c.	License nu	ımber	Т	29d. Dat	e signed (Month,	Day, Year)				
)	⊢ ≱ ⊢ 8		20111	8 MM		1	12.	110		9	121-1	DE				
	. (30. Name and address of person who	n complete company of a	eath (Item 23a) /Tre-	Print)	7. 6	100		- 1	00					
	(5			.1		,	oue D	- T		MAR	21022					
			Susan Meltzer, 31. Date filed (Month, Day, Year)	M.D.	ar's Signature	Lullam	ore K	d., Tir	nonium	, MD	21093					

DHMH 17 Rev 1/2001

State Registrar

SEP 2.9 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 5 Month BELL **Physician** 5:10AM FORGE 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept. 15, Howard County General Hospital Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Year) Director 188-16-2788 1922 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iteme 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
snt: If item 27 is marked other than "natural; or iteme 23e or 28e1 shov ury or other traumatic event, Ite Medical Examical must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Crosby Road 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 1946-Specify. 3 ☐ Widowed 4 ☐ Divorced White 1985 | Fea. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor of Construction C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Bell Addie H. Fitze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Bell Wife 1018 Crosby Road Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct. 2, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. The Glade Cemetery Walkersville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Sagies Licenses 22. Name and Address of Facility -Oueen Funeral Home & Crematory, P.A. Old Liberty Road Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death MYOCARDI **Physician** /Medical Que to (or as a consequence of): Examiner OROW MRI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ii or Attanding Physician: The law requires that the death certificate be executed after death.

after death.

I Director: After this certificate has been signed by the attending physician and in by the attending physician and in by the funest director, page 2 should be detached for use as the burital-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ nknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 3 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of centries 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) VITE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2 9 2005

Clifton Burkett UNK 05-04067 05-04067 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		•	Cei	tificate of i	Death	R	og. No. 200	5 31596
	Physici	an	1. Decedent's Name (First, Middle, Las	t)					2. Date of Deat Month	th	3. Time of Death
	/Medi		Clifton Burkett						June 14	2005	1140 A M
	Examir	ier	4a. Facility Name (If not institution, give					Location of Death		4c. County of I	Death
	Europol		3007 Shannon Driv		(In yrs. last b	oirthday)	Baltimon		8 Date of Birth	1	Birthplace (State or Foreign
Ì,	Funeral Director		2	X M 2□F	56	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 25,	1948	Country) unk
	show		10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Mary F-f sh	to	MD		Balti	more					1 ∑Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of Wha	it Country?
	ath wi	a	3007 Shannon Driv	re			21	213			unk
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, the Madical Evanti arrival be ruilled at	by Funeral	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		1	Vas Decedent of H f Yes, specify Cuba I □ Yes 2囚 No	ispanic Origin? (Spanic Origin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. black
ည် က	72 ho	Completed	15. Decedent's Ed (Specify only highest grad		16	a. Deced	ent's Usual Occupa	ation during most of worki	ina	16b. Kind of Busin	
2	within ene. then	npl m	Elementary/Secondary (0-12)	College (1-4or 5		life. L	OO NOT use retired)			
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	u	ınk		1	18. Mother's Name	unk	Asidon Sumama)	unk
Maryland	should be Ind Mental I	To Be	The date of the state of the st				unk	io. Would s Name	o (r irst, imiddie, n	naiden Sumame)	unk
lar)	12 sho and I Is ma reums	9	19a. Informant's Name/Relationship (7	ype, Print)				and Number or Rura			
a)	1 and Health em 27 ther tr		O.C.M.E. 20a, Method of Disposition		20b Place	II P	enn Stree sition (Name of	et Baltimo		yland 21: 20c. Location - City	
	Pages nent of I ant: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemet	ery, cren	natory or other plac	9)	74.6	zoc. Location - City	y or rown, State
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		21. Signature of Europeal Service Lie no	Wade, pire	ctor	St Ba	Name and Address ate Anato Itimore,	os of Facility Omy Board MD 21201	655 W.	Baltimor	e Street
	nysician /Medical Examiner		23a. Parti, Enter the disease, or com- shock, a heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused one cause on each lip a	eter	NU	er the mode of dying	g, such as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death
		Je.	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	consequence	9 of):					
	xecuted and II-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a consequence of):						
68760,	ertificate be executed ding physician and se as the burial-transil	Medical E		d							
Bo Bo	death of attended for us	Physician/Med	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year	
ς, Γ	Se ig es	by	256. Did tobacco use continuities								
Hecord	> 11 0	Completed							24a. Was an		Probably 4 Unknown a autopsy findings available
<u> </u>	9 4	mo:							autopsy perform	ned? deatl	to completion of cause of h? Yes 2□ No
VII	lysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of Death			
> 0	Physicien: this certific ral director,	P.	1X Yes 2 □ No	Hospital:				4 Nursing Hon	ne 5 🗆 Resider	nce 6 XOther (S	Specify) At Scene
	Attending F r death. ector: After by the funera	atlon:	27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of Work? 1 Very 28b. Time of Very 28c. Injury at Work? 1 Yes 28d. Describe how injury occurred 28d. Describe how injury occurred 38d. Describe how injury occurred								
	of or Attential after death	Certification:	3 Suicide 6 Could not be 4 Homicide 6 determined	28e. Place of Inju building, etc	ry - At home, f . (Specify)		et, factory, office	1	281. Location (Str. City or Town, Ballino	State) 3007	Rural Route Number, Shannon Drive
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical C	29a. Certifier 1 Certifying Phy 3 Medicel Exem	rsicien: To the best o iner: On the basis of and manner stat	f my knowledge examination a	je, death	occurred at the tim	e, date and place, a	and due to the car	use(s) and manne	r as stated. due to the cause(s)
	To thi within To the compli	Me	29b. Signature and litle of certifier	1	1		29c. License	number	29	d. Date signed (M	onth, Day, Year)
			XXX	XII	~		OC	ME	Jı	une 15, 2	2005
			30. Name and address of person who o	ompleted cause of de	ath (Item 23a)) (Туре, Г	Print) 111 Pen	n Street	Baltimo	ore. Marv	land 21201

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 9 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

			1 - State of I	Marylan	d / Depa <i>Cer</i>	irtment of Ha tificate of L	ealth and M Death		gien 2 0 0 5	31597
	Physici	an	Decedent's Name (First, Middle, Last)			2001	-	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	FRANCES 4a. Facility Name (If not institution, give street and numb	B er)		BOOK 4b. City, Town, or		SEPT.	27 2005 4c. County of Deat	8:15 A M
	Examin	er -	HOSPICE OF BALTIMORE-GII		Т		WSON			TIMORE
	Funeral Director		212-56-7216 ¹□M 2ĂF	Age (In yrs.)	last birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl 08/12/1	9. Birt	hplace (State or Foreign untry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	ath with the Marylan 123s or 28s-f show Ant be notified	tor	MD N/A	вА	LTIMOR	E				1√ Yes 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	eath v	erai	1101 ST. PAUL STREET AP			21202 Vas Decedent of His	spanic Origin? (Sp	ecity Yes or No-	U.S.A.	rican Indian,
9	urs after dea al', or items Exerulter tos		Amed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give	96?	1	Yes, specify Cubar	Nexican, Puerto Specify:	Rican, etc.)	Black, White	
5-0036	72 hours 'natural', dical Eng	d by	3 M Widowed 4 Divorced Year or Date	es:		lent's Usual Occupa				WHITE
ر 15-	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f show int, the Madical Examilian Count be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+)	(Give	kind of work done d OO NOT use retired;	uring most of work.	ing	16b. Kind of Business/	industry
212	be filed within ital Hygiene. Id other than event, the Ma	Con	12	0.01	OW	NER			JEWELER	
S & I	基語を	Be c	17. Father's Name (First, Middle, Last) ISAAC		BERMA	N	18. Mother's Name SARAH	e (First, Middle,	Maiden Sumame) KATZ	
ary	s 1 and 2 should of Health and Men item 27 is marke other traumatic	To	19a. Informant's Name/Relationship (Type, Print)					al Route Numbe	r, City or Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 is		ALAN GIBBER / ATTORNEY	00h B		the state of the s			BALTIMORE,	
200	ages 1 nt of H t: if ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Sta	ate a	emetery, cren	sition (Name of natory or other place MUNO CONG	9)	R / 2005	BALTIMORE,	
7,200 altimore,	permit. Page Depertment of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	CIT					SON & BROS.	
4 8	Depermine Timbor Sun in		seato M. wither						IKESVILLE,	MD 21208
2			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death th line.	h. Do not ent	er the mode of dying	g, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	as a consequ	nence of):					weeks
70	Examiner		Sequentially list conditions, b. Lcc	Ulik		lar				mosths
The State of the S	pe iis	lner	ri any, leading to immediate	as a consequ		in Mi	eggs lav			G-Sarc
ll v	executed n and ial-transit	Examiner	,	as a consequ	uence or).	CT De		in the second		7-113
25	icate to executed physician and s the burial-transit	dical	d. Cer	re 600.	1AS CU	ILAR DI	stalit			yers
39 x 77.c	leath certifici ettending pl		IF FEMALE: 23c. If yes, outco	me of pregna	incv				22d Date of dol	in an a
Bo Bo	death of etten	Physician/M	23b. Was decedent pregnant 1 Live birth in the past 12 months? 4 Pregnant	h 2 ∐ Feta ntattime of di	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
HO.9	at the d by the etache	Phys	9 ☐ Unknown \		lai - i - ab -		o in Burt	22a Dida		the course of death?
Je,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to deat	th but not resi	ulting in the ui	nderlying cause give	en in Part I.	1 🗆 Y	es 2 No 3 Pr	obably 4 Unknown
000	law rec as bee 2 shor	Completed						24a. Was a	an 24b. Were au	topsy findings available completion of cause of
₩.	t. The cate his	Соп						perfor	med/? death?	2 No
\ <u>;</u>	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inc	nationt 2	ER/Outpatien	t 3 DOA Othe	26. Place of Deat		ne) ence 6 💢 ther (Spe	city la salata
י ס ר	ng Phy ter this neral o	 	27. Manner of Death 28a. Date of (Month,		28b. Time of Injury				ow injury occurred	Washed
Division of Vita	tendir Jeath. tor: Af the fu	catic	2 Accident investigation			M 1 🗆 \	res 2 □ No	not Leasting /6	treat and Musebases D	Control March
Divi	afor Al s after (il Dirsc d in by	Certification:	determined 288. Place of	f Injury - At no j, etc. <i>(Specif</i>)	y) y)	eet, factory, office		City or Tow	treet and Number or Ru n, State)	irai noule Number,
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	edicai C	29a. Certifier Check only 2 Medical Examiner: On the bas and manne	is of examina	wledge, death	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the dred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	the second secon					29c. License number				h, Day, Year)
			Klarkons)		DE	8303		Systemha	-21205
	30. Name and address of person who completed cause of d					Print)	rles St	13 250	NMD ZI	27200
	Sta			gistrar's Signa	ture de	eds.				

State of Maryland / Department of Health and Mental Hygiene-1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ROOSEVELT COLLINS 09-27-2005 10:10 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5740 CEDONIA AVENUE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Hours Director 75 Yrs. 212-26-1585 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if itam 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Exercine manake notified at MD BAI TIMORE 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5740 CEDONIA AVENUE 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □X Yes 2 □ No If Yes, Give Year or Dates: 51-4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No SpecifyBLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 51 - 5915. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRACTOR OPERATOR 11 STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Pages 1 and 2 should be NOAH COLLINS, SR. NETTLE DE SHAZO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5740 CEDONIA AVENUE, BALTO., MD 21206 SOPHIA COLLINS/WIFE if item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department o Important: if any injury or once. GARRISON FOREST 9/30/05 OWINGS MILLS, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licenses 1701 LAURENS ST., BAITG., MD 21217 23a. Part. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tran end Due to (or as a consequence of): physicien by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending death. 1 Yes 2 No investigation 2 Accident the within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) ZU Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0025773 ORLEANS ST BALTIMORE, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 9 2005 Registrar

DHMH 17 Rev 1/2001

05-05470 Stevie Clark

Amend item/23a, 27, perME, 6848, 10/19/05 II.

						Ce	rtificat	e or L	Jealii			Reg.	No.		31599
ysician		 Decedent's Name (First, Midd. Stevie Clark 	le, Last)								2. Date of Month		12,	Ž ^{ear} 2005	3. Time of Death
Medical aminer		1a. Facility Name (If not institution	n. aive stree	t and numb	oer)		4b. City.	Town, or	Location of	of Death	Augu	ist	4c. County		17:51
ammer		Johns Hopkins			,				imore				,		
eral	5	5. Social Security Number	6. Sex	7.		last birthday)		r 1 Year	If Under Hours		8. Date of (Month Jan (Birth Day Ye	ear)	9. Birthp	lace (State or Foreig
ctor		578-88-1629	11⊠ M	2111	53	Yrs.	Months	Days	110013		Jan (5, 1	1952	Cour	unk
	-	Usual Residence of Decedent 10a. State 10b. County	,		10c. Ci	ity, Town or Lo	ocation							1	0d. Inside City Limit
page. To Be Completed by Funeral Director		DC			Was	shingto	m								1 ☐ Yes 2 🛣 N
Director	1	10e. Street and Number				, <u></u>	10f. Zip	Code			unk	10g.	Citizen of	What Cour	itry?
ai D		1235 42nd Stre	et SE				:				unk		USA		
Funerai	1	11. Marital Status unl	A	Armed Force			Was Deced	dent of His	spanic Ori n, Mexicar	gin? (Spe	ecify Yes or Rican, etc.	No-		ce - Americ ck, White,	
oy F		1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	. 1	∏Yes 2. fYes, Give Year or Date	_		1 ☐ Yes	2 K) No	Specify:				Specif	y: h 1:	ack
Completed by	-	15. Deceder	nt's Education	on		16a. Dece	dent's Usua	al Occupa	ation			166	o. Kind of B		
pie	-	(Specify only higher Elementary/Secondary (0-12)	1	mpleted) College (1-4	or 5+)	(Give	kind of wo DO NOT us	rk done d	<i>lurina</i> mos	t of worki	ng				
Con		unk			uńk						unk				unk
Be		17. Father's Name (First, Middle,	, Last)				unk		18. Mothe	er's Name	First, Mic	ldle, Maid	den Suman	пө)	unk
2		19a. Informant's Name/Relation:	ship (Tune 1	Orine)		10h 14alli		· (Ca		0	10-1-1				0.11
		O.C.M.E.	silip (<i>Type, T</i>	- runij									ity or Town, land	-	Code)
	2	20a. Method of Disposition			20b. I	Place of Dispo	osition (Nan	me of			Date	4	. Location		wn, State
		1 Burial 2 Cremation 4 Donation 5 B Other (ate	cemetery, crei	matory or o	otner piace	9)			6			
	1	21. Sig above of Funeral Service		//	rector	. 8	Name an	nd Addres	s of Facilit	Your	1 655	LI I	0.1+4		Throat
		Mille		1 10			altin	nore,	MĎ	2120	i obb	W • 1	Jarti	nore i	Street
al er		Immediate Caûse (Final disease or condition resulting in death)	Ca. C		ine.	ns of d					and a			emia	Approximate Interval Between Onset and Death
Examiner		disease or condition	a. <u>C</u>	Due to (or	cation	quence of):								emia	Interval Between
edicai		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>C</u> b c. d.	Due to (or	cation r as a consec r as a consec	quence of):								emia	Interval Between
edicai		disease or condition resulting in death) Schemitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — c. d.	Due to (or Due to (or Due to (or f yes, outco	cation ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec	quence of): quence of): quence of):		tes T					1euk	emia	Interval Between Onset and Death
Physician/Medicai		disease or condition resulting in death) Schemistry list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. — c. d.	Due to (or Due to (or Due to (or f yes, outco Live birtl Pregnan	cation ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec	quence of): quence of): quence of): ancy al death 5[liabet	regnancy	nelli	tus a	and a	cute	leuk	te of delive	Interval Between Onset and Death
by Physician/Medicai Examiner		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. — c. d.	Due to (or Due to (or Due to (or f yes, outco Live birtl Pregnan	cation ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec	quence of): quence of): quence of): ancy al death 5[liabet	regnancy	nelli	tus a	and a	cute	leuk	te of delive	onset and Death Onset and Death Onset and Death Onset and Death
by Physician/Medicai Examiner		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. — c. d.	Due to (or Due to (or Due to (or f yes, outco Live birtl Pregnan	cation ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec	quence of): quence of): quence of): ancy al death 5[liabet	regnancy	nelli	tus a	23e. C	cute	23d. Da Mc	te of deliverenth tribute to the 3 Prob	onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death
by Physician/Medicai Examiner		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. — c. d.	Due to (or Due to (or Due to (or f yes, outco Live birtl Pregnan	cation ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec ras a consec	quence of): quence of): quence of): ancy al death 5[liabet	regnancy	nelli	tus a	23e. C	cute	23d. Da Mc coo use cont 2 No 24b.	te of deliveranth tribute to the 3 Prob	ory Day Year Day Year Day Onknow
Be Completed by Physician/Medical		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are sugariner?	b. — c. d. 23c. I	Due to (or Due to (or Due to (or f yes, outco Live birt Pregnan Unknow uting to deat	cation ras a consec ras a conse	quence of): quence of): quence of): ancy al death 5[liabet	regnancy pecify)	nelli in in Part I	tus a	23e. C	id tobace Yes Vas an utopsy erformed is 2 □	23d. Da Mc coo use cont 2 No 24b.	te of deliveranth tribute to the 3 Prob	ory Day Year Le cause of death? Ably 4 Unknown Composite the cause of death?
To Be Completed by Physician/Medical		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. — c. d. 23c. I	Due to (or Due to (or Due to (or f yes, outco Live birtl Pregnan Unknow uting to deal	cation ras a consect ras a con	quence of): quence of): quence of): quence of): ancy al death 55 sulting in the u	Ectopic production of the control of	regnancy pecify)	nelli in Part I	tus a	23e. C 1 24a. V 1 24a V 1 1 20 Y of 1 Chrock or	eid tobace Yes vas an utopsy erformed s 2 1	23d. Da Mc co use cont 2 \sum No 24b.	te of deliveranth tribute to the stribute to	onset and Death Onset and Death Onset and Death Onset and Death Part of the Cause of death? About the Cause of death? About the Cause of death? About the Cause of death?
To Be Completed by Physician/Medical		disease or condition resulting in death) Schooling in death) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. I	Due to (or Due to (or Due to (or f yes, outco Live birt Pregnan Unknow uting to deat	cation ras a consect ras a con	quence of): quence of): quence of): quence of): ancy al death 55 sulting in the u	Ectopic production of the control of	regnancy pecify) cause give	nelli an in Part I	tus a	23e. C 1 24a. V 1 24a V 1 1 20 Y of 1 Chrock or	eid tobace Yes vas an utopsy erformed s 2 1	23d. Da Mc co use cont 2 \sum No	te of deliveranth tribute to the stribute to	onset and Death Onset and Death Onset and Death Onset and Death Part of the Cause of death? About the Cause of death? About the Cause of death? About the Cause of death?
To Be Completed by Physician/Medical Examiner		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. I	Due to (or Due to (or Due to (or Due to (or I Live birtlet Pregnan Unknow Uting to deat Ital: It	cation ras a consect ras consect ras a consect ras consect ras consect ras consect ras consect ras consect ras consect ras consect ras consect ras consect ras consect ras consect ras consect ras conse	quence of): quence of): quence of): quence of): ancy al death 5 [sulting in the u BER/Outpaties 28b. Time of Injury nome, farm, st	□Ectopic pr □ Other (sp underlying c	regnancy pecify)	nelli in Part I	tus a	23e. C 1 24a. V 2	old tobace Yes Vas an utopsy erformed as 2 U young lesidence be how i	23d. Da Mc co use cont 2 No 24b. 17 No e 6 Oth niury occur	tribute to the stribute to the stribute to the stribute to the stribute to cordeath?	onset and Death Onset and Death Onset and Death Onset and Death Part of the Cause of death? About the Cause of death? About the Cause of death? About the Cause of death?
Certification; To Be Completed by Physician/Medical		disease or condition resulting in death) Scheduly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 24c. I d. 24c. I d. 25c. I d. 26c. I d. 26c. I d. 26c. I d. 27c. I d. 26c. I d. 27c. I	Due to (or Due to (or Due to (or If yes, outco I Live birtl I Pregnan I Unknow uting to deal ital: 12 Inp 8a. Date of (Month, 8e. Place of building	cation ras a consect quence of): quence of): quence of): quence of): ancy al death 5 [sulting in the u BER/Outpaties 28b. Time of Injury nome, farm, st	□Ectopic pr □ Other (sp underlying c Int 3□ DO of 2 M reet, factory	regnancy pecify)	26. Place 26. Place 27. 4 Nu at 28. 2	e of Deathursing Hou	23e. C 1 24a. V 2 p 1 p 1 c 1 c 2 c 2 c 1 c 2 c 1 c 2 c 2	Old tobace Yes Yas an utopsy erformed is 2 1	23d. Da Mc co use cont 2 No 24b. 17 No 24b. 17 No e 6 Oth niury occur at and Numbitate)	te of deliveranth tribute to th 3 Prob Were auto prior to cordeath? 1 Ves the (Specify red	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Day Year Decause of death? ably 4 Unknow psy findings available in of cause of 2 No // Route Number.	
To Be Completed by Physician/Medical		disease or condition resulting in death) Schemistry list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. I 23c. I 3 3 3 4 4 5 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or Due to (or Due to (or Due to (or I Live birtl Pregnan I Uknow Unknow Unknow Ital: 12 Inp 8a. Date of (Montn, Montn, Be. Place of building In: To the bas.	cation ras a consect quence of): quenc	☐Ectopic pr☐ Other (sp. underlying counderlying counderl	regnancy pecify)	26. Place or 4 Nu at ?? fes 2 I	of Deathursing Hor	23e. C 1 24a. V 2 p 1 24a. V 2 p 1 24b. Chock or 28d. Descri Olid tobace Yes Yas an utopsy erformed as 2 1	23d. Da Mc co use cont 2 No 24b. 17 No 24b. 17 No e 6 Oth nijury occur it and Numb itare) e(s) and ma and place, Date signe	te of deliveranth tribute to th 3 Prob Were auto prior to cord death? The Yes The Company of the control of the cord anner as stand due to d (Month,	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Day Year De cause of death? Ably 4 Unknow psy findings available in of cause of 2 No No Route Number, ated. the cause(s) Day, Year)		
Certification; To Be Completed by Physician/Medicai Examiner		disease or condition resulting in death) Schemistry list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. I 23c. I 3 3 3 4 4 5 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or Due to (or Due to (or Due to (or I Live birtl Pregnan I Uknow Unknow Unknow Ital: 12 Inp 8a. Date of (Montn, Montn, Be. Place of building In: To the bas.	cation ras a consect quence of): quenc	☐Ectopic pr☐ Other (sp. underlying counderlying counderl	regnancy pecify)	26. Place or 4 Nu at ? fes 2	of Deathursing Hor	23e. C 1 24a. V 2 p 1 24a. V 2 p 1 24b. Chock or 28d. Descri Olid tobace Yes Yas an utopsy erformed as 2 1	23d. Da Mo co use cont 2 No 24b. 17 No 24b. 17 No e 6 Oth injury occur at and Numb itare) e(s) and ma and place,	te of deliveranth tribute to th 3 Prob Were auto prior to cord death? The Yes The Company of the control of the cord anner as stand due to d (Month,	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Day Year De cause of death? Ably 4 Unknow psy findings available in of cause of 2 No No Route Number, ated. the cause(s) Day, Year)		
Certification; To Be Completed by Physician/Medical Examiner		disease or condition resulting in death) Schemistry list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 23c. I d. 24c. I d. 24c. I d. 25c. I	Due to (or Due to (or Due to (or Due to (or I Live birtlet of Pregnand or Unknown of the last of the base and manned of the last of the last of the base and manned of the last of the base and manned of the last of the	cation ras a consect quence of): quenc	Ectopic production of the cocurred the occurred investigation (Print)	regnancy pecify) DA Other 28c. Injury Work 1 1 y y, office at the tim h, in my op C. License	26. Place 26. Place 27. 4 \(\text{Nu}\) 26. re, date an onumber 26. C. M.	e of Deathursing Horald place, at the occurrence.	23e. Days of Check or me 5 F28d. Described at the tire	id tobace Yes Vas an utopsy erformed is 2 1 2 2 2 2 2 2 2 2	23d. Da Mc co use cont 2 No 24b. 17 No 24b. 17 No e 6 Oth nijury occur it and Numb itare) e(s) and ma and place, Date signe	te of deliveranth tribute to the series of	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death? ably 4 Unknown Death Onset and Onset	

State of Maryland / Department of Health and Mental Hygiens 31600 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Margie L. Campbell September 21 2005 3:32a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Subacute Care Center Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Vrs Director 65 1939 Washington, DC 214-36-1630 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Prince George by Funeral Director Lanham 1x Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 8810 Orbit Lane 20706 USA filed within 72 hours after death Itame 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced natural Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Health Insurance Co. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 is marked other t jury or other traumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Bean Ruth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Campbell/Husband 8810 Orbit Lane, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 9/23/05 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine to the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, cian by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 KYes 2 □ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Mes 12070 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 29 Registrar 2005

DHMH 17 Rev 1/2001

			For State	State	of Marylar		artment of F		and Me				21601
10.7		24	Registrar 1. Decedent's Name (First, Mid	dle, Last)		Ce	runcate or	Dealii	2	Date of Dea		2005	3. Time of Death
ैं ∯ F	hysici		Carol	Ann		Carces	si		5	Month Septem	_{Day}		05 10:54 A M
	/Medio Examin		4a. Facility Name (If not institut	ion, give street and n	umber)		4b. City, Town, o	r Location o				County of Dea	
			Joseph Riche			to a februar d	Balti If Under 1 Year		24 Hre o	D (D)	1	0.5:	
	uneral rector		5. Social Security Number 172–40–2079	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs		Months Days	Hours	Min.	Date of Birt (Month, Da	y, Year)	C	thplace (State or Foreign ountry) nnsylvania
g			Usual Residence of Decedent								0, 1	740 161	
arylar	show	-	10a. State 10b. Coun	•		ity, Town or Lo	ocation						10d. Inside City Limits 1
the M	28a-f	recto	PA Clai	ion	C.	larion	10f. Zip Code				10a, Citi	zen of What C	71
h with	38 or	Funeral Director	103 S. 7th Av	renue			1621	4			U	.S.A.	
r deat	ama 2	iner	11. Marital Status	12. Was De	cedent Ever in (J.S. 13.	Was Decedent of H	lispanic Orig	gin? (Specif	y Yes or No-		14. Race · Ame Black, Whi	
s afte	l m	by Fu	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 🛣 Divorc	If Yes G	2 📉 No live Dates:		1 ☐ Yes 2X No	Specify:				Specify: -	White
. I Z I 3~UU30 within 72 hours after death with the Maryland ene.	od other than "natural", or Itama 23a or 28a-f show event, the Medical Examinat must be nutified at		15. Deced	ent's Education		16a. Dece	dent's Usual Occup	ation			16b. Kii	nd of Business	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Med "n	Completed	(Specify only high Elementary/Secondary (0-12	nest grade completed College	(1-4or 5+)	life.	kind of work done DO NOT use retired	during most d)	t of working	County			
V P D	nt th		17. Father's Name (First, Middle	4			Teacher	18 Mothe	ar's Nama //	First, Middle,		ool Dis	strict
YIANG build be file Mental Hy	to bes	To Be	Colin Hileman	•				_	h Logi		Malderi	Surramey	
C 2 73	Is marked raumatic ev	F	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address (Street				er, City o	Town, State,	Zip Code)
and and	itam 27 is marke other traumatic		Andrea J. Car	cesi (Da	ughter)	The second second	Reading A	Ave.,					
Saltimore Dermit. Pages 1 Department of He	or oth		20a. Method of Disposition 1 X Burial 2 ☐ Crematio		State	cemetery, cre	osition (Name of matory or other place		9/22/			cation - City or	
IIIIII nit. Pa artmer	Important: If its any injury or of once.		4 ☐ Donation 5 ☐ Other 21. Sign ure Funeral Service		St		ville Ceme		tv		Stra	ttanvil	le, PA
Dep.	any onc	-	Lennis	Pita	men		2 Name and Addre Goble Fui 330 Wood			on. P	A 16:	214	
12 A	4		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause on	caused the dea	th. Do not en							Approximate Interval Belween
	sician		tmmediate Cause (Final disease or condition resulting in death)	-a. Mela	, n ome -	witely	metartat:	e indi	d cha	rain			Onsel and Death
	edical miner		resulting in death)	Due to	(or as a conse	quence of):			0				
		her	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	quence of):							
of the Delta	nd Iransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
o be executed	cien a burral-	al Ex	resulting in death) Last	Due to	o (or as a conse	quence of):							
	been signed by the attending physicien and should be detached for use as the burial-transit	0		d									
. BOX 68/	ending r use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr birth 2 ☐ Fet		⊒Ectopic pregnancy	,			2	3d. Dale of de	
	the att	sicle	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at time of		Other (specify)					Month	Day Year
T ta	ed by detacl		Part II. Other significant cond	itions contributing to	death but not re	sulting in the u	ınderlying cause gıv	ren in Part I.		23e. Did to	obacco u	se contribute l	o lhe cause of death?
dS,	n sign	d by								101	res 2	K No 3□P	robably 4 Unknown
Mecord he taw requir	s bee	plete								24a. Was		24b. Were a	utopsy findings available
_ ⊢	ate ha	Completed								autop perfo 1 TYes	rmed?	death?	completion of cause of
OT VITAI Physician: 1	this certificate has brail director, page 2 s	Be	25. Was case referred to medi examiner?	Hospital:			nt 3E DOA Oth	000		Check only o			TN3176NT
Phys	0 0	. To	1 Yes 2 No 27. Manner of Death	1 1	Inpatient 2 of Injury nth, Day Year)	☐ ER/Outpatie 28b. Time o	III 3 DOA	4 🗆 140		5 Residuel		Other (Specy occurred	ecity) Hastice
VISION Attending	r: After thi	ation	1 Natural 5 □ Pen 2 □ Accident inve	ding (Mo stigation	nth, Day Year)	Injury		rk? Yes 2 □ t	No				
DIVISION I or Attending after death.		Certification:		ld not be rmined 28e. Plac buil	ce of Injury - At I ding, etc. (Spec	home, farm, st	reel, factory, office		28	Location (S City or Tox			ural Route Number,
pital c	eral D		29a. Certifier 1 🗶 Certif	ying Physician: To th	an host of mu ke	lowladge desi	th assurant at the tu	mo dato an	d place and	d due to the	201120(2)		
Lo the Hospital within 24 hours a	e Fun letely	Medical	(Check only 2 Medic	at Examiner: On the	basis of examin nner stated.	ation and/or in	nvestigation, in my c	pinion, dea	ith occurred	at the time,	dale and	place, and du	e to the cause(s)
To th	To the Funeral Directory completely filled in the	Me	29b. Signalure and title of cert	fier		-	29c. Licens					e signed (Mon	
	.(10716	1,111	~ MD			1476				18.50	305
	M		Raynond W	4 440	2 my 2 mg 26	CHARLO	C CT 2201	TIMORE	E, M	0 21	204		
	Sta	ate	31. Date filed (Month, Day, Ye	ar) 32.	Registrar's Sign	nature	· · ·						
	Regist	rar	SET 2	9 2005	Mar 1	S. P.	and a						

DHMH 17 Rev 1/2001

NDREW B.CULLISON 5-04247 KD

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of	f Health a	and Mental H	lygiene 0	05	31602	
	Physici		1. Decedent's Name (First, Middle, Last) Andrew B. Cullison					2. Date of Month JUNE		0Ŏ5°	3. Time of Death 5:17P. M	
f	/Medic Examin		4a. Facility Name (If not institution, give st 6654 ROBERTS COURT	reet and number)			n, or Location of BURNIE	of Death		y of Death ARUND	EL	
	Funeral Director		unk	7. Age (In yrs. Id M 2 F 52	ast birthday) Yrs.	If Under 1 Ye Months Da		Min. Sept 3. Date of (Month,	Birth Day, Year) 3, 1952	9. Birthi	place (State or Foreign ntry) unk	
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Anne Arun		, Town or Lo						10d. Inside City Limits	
	or 28e-	Irect	10e. Street and Number	del ol	.cii bai	10f. Zip Coo	le		10g. Citizen of	What Cou	ntry?	
	ath wit	ralD	6654 Roberts Court				061		14.5	ice - Ameri	unk	
036	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "neturel", or Itams 23a or 28e-f show avent, I've Medical Examinar must be notified at	by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 	ì	Mas Decedent f Yes, specify (I□Yes 2⊠		igin? (Specify Yes or n, Puerto Rican, etc.)	Spec	ack, White,		
21215-0036	thin 72 ho e. en "natur Mulcal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	it of working	16b. Kind of	6b. Kind of Business/Industry						
2	filed wi Hygien Sthar th	Con	17. Father's Name (First, Middle, Last)	unk		unk	18 Moth	unk er's Name (First, Mide	dle Maiden Suma		unk unk	
		To Be		- China				er or Rural Route Nu				
Ma	th and 2 st is n		19a. Informant's Name/Relationship (Typo O.C.M.E.	e, runj		-		ltimore, N				
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as <u>000.0</u> .		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 ☒ Other (Specify)	moval from State	lace of Dispo	sition (Name o natory or other	f	Date	20c. Location			
Balti	permit. Departn Imports any inju		21. Sign ture of Funeral Service License	livector	S B	tate ^{and An} altimor	atomy le, MD	Soard 655 21201	W. Balti	more	nore Street	
	rnysician /Medical Examiner	ner	Zsa. Part . Enter the disease, or complication, or heart failure. List only on Immediate Cause (Final disease or conflicion resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	EIZURE	DISORI		cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death	
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physiclan/Medical Examiner	resulting in death) Last	Due to (or as a consequence of pregnation)					224.5			
.O. Box	the che	ysiclan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3[Ectopic pregna Other (specify				ate of deliv	Day Year	
۵.		by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	e given in Part	1	□Yes 2 No	ntribute to	the cause of death?	
Vital Records,	The law requires rate has been sign page 2 should be	Completed	ATHEROSCLEROT	IC CARDIOVASC	ULAR D	ISEASE	· · · · · · · · · · · · · · · · · · ·		dislan 24b	. Were auto prior to co death? 1 2 Yes	opsy findings available ompletion of cause of	
ita	ilcian; Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					e of Death (Check or	lv one)	-/-		
of	ding Phys h. After this funeral di	2	TX Yes 2 No 27. Manner of Death 1 Natural 5 Pending 21 Accident investigation	ospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	Other: 4 Nursing Home 5 Residence of 28c. Injury at Work?			esidence 6 XO	ther (Speci	SCENE		
Division	al or Attanding s after death. il Diractor: After	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	M 1 ☐ Yes 2 ☐ No m, street, factory, office 28f. Location (Street and Number City or Town, State)					ral Route Number,	
	To the Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	edical (ician: To the best of my kno ler: On the basis of examina and manner stated.								
)	To the lewithin 2. To the lecomplete	Me	29b. Signature and title of certifier	(Vas		C	cense number CME			29d. Date signed (Month. Day, Year) JUNE 24, 2005		
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	PT11 Pe	enn Str	eet Balti	more, Ma	rylan	d 21201	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	nation .						

crn			For State Registrar		State o	f Marylar	-	artment <i>rtificate</i>				lental Hy	giene (05	31603	
	Physicia		1. Decedent's Name Horace Cl									2. Date of De Month June		Year 2005	3. Time of Death	
	/Medic Examin		4a. Fecility Name (If	not institution	s give street and nu Street, A		t 326	4b. City, To	own, or		of Death	June		unty of Death	10:56 A [™]	
	Funeral Director		5. Social Security No		6. Sex 1 M 2 □ F	7. Age (In yrs. 81		If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bi June 2	rth ay, Year 24		place (State or Foreign ntry) unk	
	nyland show		Usual Residence of 10a. State	Decedent 10b. County			ity, Town or Lo							1	10d. Inside City Limits	
	ith the Marylar or 28a-f show se notified at	Director	MD 10e. Street and Nun				1timor	10f. Zip C			···		10g. Citizen	of What Cour	1½∏Yes 2 ☐ No ntry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show eny injury or other treumatic event, the Medical Examinat must be notified at once.	Funeral (11. Marital Status	unk	Armed Fo	edent Ever in U	J.S. 13.		L218 ent of His by Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	o- 14.	Race - Americ Black, White,		
-0036	hours after iturel', or l	þ	1 Never Marrie		If Yes, Gi Year or D	ve	.,	1 ☐ Yes 21		Specify:				whit of Business/In		
Maryland 21215-0036	d within 72 jiene. r then "na	Completed	(Speci	ify only highes	College (1-4or 5+) unk	(Give	kind of work DO NOT use	done du	uring mos	it of worki	unk	TOD: Name of	, Daginggan	unk	
rland 2	uid be filed Jental Hyg rked othe	To Be C	17. Father's Name ((First, Middle,	Last)			unk		18. Mothe	er's Name	(First, Middle	, Maiden Sur	name)	unk	
, Mary	and 2 shorester and N 27 Is ma	·	19a. Informant's Na		hip (Type, Print)			-				ore, Ma			Code)	
Baltimore,	Pages 1 and of He ent of He ent: If item ury or oth			Cremation	3 □Removal from pecify) in sta	State	Place of Dispo cemetery, cre	osition (Name matory or oth	e of ner place)	C	Date	20c. Locati	on - City or To	own, State	
Balt	permit. Departr Import eny inji		XIVI	10/1	Licensee		Ва	iltimo	re,	MD 2	1201	655 W.		more S	treet	
	Physician		Immediate Cause (Final	complications that only one cause on	-						. /		NA	Approximate Interval Between Onset and Death	
	/Medical Examiner	_	disease or condition resulting in death) a. HTHE/CLUTIC CANDICULAR CANDICULAR CANDICATED THE Due to (or as a consequence of): b. Due to (or as a consequence of):													
	secuted and I-transit	Examiner														
38760,	icate be executed physician and s the burial-transit	dlcal			(a		1									
.O. Box 6	Hospitel or Attending Physicien: The law requires that the death certific 4 hours after death. Funerel Director: After this certificate has been signed by the attending Fiely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1 Live	tcome of pregn pirth 2 Feta nant at time of a own	al death 3[⊒Ectopic pred ☐ Other (spec				40	23d.	Date of delive Month	ery Day Year	
ds, P	v requires that the de been signed by the s should be detached	by	Part II. Other signif	icant condition	ons contributing to c	eath but not re	sulting in the u	inderlying cau	use givei	n in Part I.	,		tobacco use d Yes 2 N		he cause of death?	
al Recoi	: The law rec cate has beel page 2 shou	Completed										24a. Was auto perfo 1 ☐ Yes	an 24 psy prmed? 2 2 No	death?	psy findings available mpletion of cause of	
Division of Vital Records, P.O.	ig Physicien: ter this certific heral director,	To Be	25. Was case referrexaminer? 1 1 Yes 2 2 27. Manner of Death	No h	Hospital: 1 28a. Date	Inpatient 2 of Injury	ER/Outpatie		Other	r: 4□ Nu at	ırsing Hoi	me 5 Resi Residence Residence Reside	dence 6 🗓		y) at scene	
Divisio	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation investigation 1 State 1 S								HUWE TO 28f. Location (City or To ATT.316	Street and Ni	SUI ST. 1/2	al Route Number, VC STVEET		
	he Hospit n 24 hour he Funere	Medical (29a. Certifier (Check only one)	1 Certifyir 2 Medicel	g Physicien : To the Examiner : On the b and mar	e best of my kn asis of examination oner stated.	owledge, deat ation and/or in	h occurred at vestigation, i	t the time n my opi	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) and	manner as s	tated. the cause(s)	
	To the withing To the complex	×	29b. Signature and	title of certifie	M.	IX		29c.	License O	number				gned (Month, 5, 200	,	
			30. Name and address		who completed cau		m 23a) (Type,		1 Pe	nn S	tree	t Balt				
	Sta Registr		31. Date filed (Mont	th, Day, Year) SEP 2	2005	legistrar's Sign	ature	askis					Baltimore, Maryland 21201			

			1 - For State Registrar	State of N	/larylan		artment of F		nd Mental Hy	giene (005	31604
	Physici	an	Decedent's Name (First, Middle, George Da.)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,		er)		4b. City, Town, o	or Location of	SPT Death	4c. Co	Dunty of Death	
	Examin	ier		AL OF B		NORE			474		N/A	
	Funeral		5. Social Security Number 239-52-8484	5. Sex 7. A 1 ☑ M 2 ☐ F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Month, Da	th ly, Year)	9. Birth	nplace (State or Foreign untry) J. Carolina
	Director		Usual Residence of Decedent	37	68	113.			Apr.	23, 1	937 N	.Carolina
	nyland thow	Ĺ	10a. State 10b. County		10c. Cit	ty, Town or Lo						10d. Inside City Limits
	he Ma	ecto	Maryland N/A 10e. Street and Number			Balt	imore			10- 01	n of What Co	1X Yes 2 □ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural" or Items 23s or 28s-f show other traumatic event, II a Medical Examinar must be intilliad at	Funeral Directo	2605 Loyola So	outhway			10f. Zip Code 212	15		USA		untry
	ems 2	nera	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	.S. 13.	Was Decedent of H	Hispanic Origi an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14.	Race - Amer	
36	s after	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced] No		1 ☐ Yes 2 ☐ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	St	pecify:Bla	
21215-0036	2 hour	ted b	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/I	Industry
215	within 7, ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)	(Give life.	kind of work done DO NOT use retire	during most (d)				
	filed withi Hygiene. other than		10th grade 17. Father's Name (First, Middle, La	astl		Truc	k Drive		s Name (First, Middle			er Company
lanc	should be find Mental His marked of	To Be	Unk.						ulah Dal		mamo)	
Maryland	2 shou and M is mar sumat	-	19a. Informant's Name/Relationshi	p (Type, Print)		-1		and Number	or Rural Route Numb	er, City or T		(ip Code) 21215
	other tra		Pearl Dale/ W:	ife	205.5	_	Loyola	Sout	hway Bal		ce,Mar	
nor	8° = ₽		1 □ Surial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		1 ,	cametery cre-	natory or other pla n Cemet	ery 9			•	, Maryland
Baltimore,	그 된 원 글 .		21. Signature of Funeral Service Li		-					Harri	s Fur	neral Home
8	permi Depa impo any ii		Dering G	Jarre.							more	Md 21215
			23a. Party Enter the disease or c shock, or heart failure. List of tmmediate Cause (Final	nly one cause on each	i line.		er the mode of dyir	ng, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	aDue to (or a		NON A						6 days
	Examiner		Sequentially list conditions	b	mu	ceu	LUNG C	Anter	Stage I	7		2415
11	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	juence of):						,
Jan 1	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a conseq	juence of):				<u></u>		
8760,	e y	Physician/Medical		d								
9 xo	death certifica attending ph I for use as tl	/Mec	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancy				230	d. Date of deli	ven/
B	death e atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	at time of o]Ectopic pregnanc] Other (s <i>pecify</i>) _	у			Month	Day Year
P.0	that the de led by the a detached t	Phys	9 Unknown	9□ Unknown		10. 1. 1			00 - Did.			
	signed d be dei	by	Part II. Other significant condition	diabetes	, LG	outing in the v	lemia	ren in Part I.		Yes 2 1		the cause of death?
Records,	w requires been s should	ojete	cisht onemine	nectory +	Fac	Lunge	cances.		24a. Was		24b. Were au	topsy findings available
Re	sician: The law s certificate has b lirector, page 2 s	Completed	prior pulm		mbely	15	Conne		auto perfo	ormed?	prior to c death? 1 ☐ Yes	completion of cause of
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	1			0.4		of Death (Check only o	one)		
of \	Physic this c	; To	1 Yes 2 No	Hospital: 1 Ninpa		ER/Outpatier	-	4 Nuis	sing Home 5 Resi			cify)
	nding P th. :: After t	ation	1 Natural 5 Pending 2 Accident in estiga	(Month, L	Day Year)	Injury	Wo	rk? Yes 2∐N		,,,,,		1
Division	i or Attendii after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of	Injury - At h	ome, farm, st	reet, factory, office		28f. Location (City or To		lumber or Ru	ral Route Number,
Q	pitai o		29a. Certifier 1 Certifying	Physicians To the he	at of my lene	uuladea daat	h d at the ti	== dete end	place and due to the		1	and the second second
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical E.	Physician: To the be xaminer: On the basis and manner	of examina	ation and/or in	vestigation, in my	ppinion, death	occurred at the time,	date and pla	ace, and due	to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	A 1	2/	1	29c. Licens		2	29d. Date s	signed (Month	n, Day, Year)
F			· Con	-(N.43	Sy	,		5-00	U	9/-	27/05	
	3		30. Name and a dress of person w	no completed cause o	death (In	n 23a) (Type,		H Has	PITAL OF	BAL	TIMORI	E
	Sta		31. Date filed (Month, Day, Year)	32 Regis	strar's Signa	tyre /	sele			- 1	1	
	Regist	rar	SEP 2 9	2005	The state of	1						

			1 - State Amend Item#5 Registrar	State of Marylan per FH G848 10	d / Depa)/13/Q	artment of H	ealth and Death	Mental Hy	giene	05 ′	31605
			1. Decedent's Name (First, Middle, La					2. Date of De	eath	00	3. Time of Death
	Physici /Medio	al	MAGGIE C. DIG			4h Ch. Taur	1	09.15.			11:30 AM
	Examir	er	4a. Facility Name (If not institution, git 3031 SPALDING	AVENUE		4b. City, Town, or BALTIMO	RE		4c. Cour	N A	
	Funeral Director		/ / _ //i_/ibxu	Sex 7. Age (In yrs. 1 ☐ M 2 🗷 F 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	rth ay, Year) 1917	9. Birthpla Countr ALAB	ce (State or Foreign y) AMA
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				100	d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show frast be notified at	Director	MD NA	BAL	MORI	Ξ					1 Yes 2 No
	with th	Dire	10e. Street and Number	AUC 4 11 10		10f. Zip Code	-		•	of What Countr	y?
	ns 23a	Funeral	3031 SPALDING	AVENUE 12. Was Decedent Ever in U	S. 13.	2121 Was Decedent of His		Specify Yes or No		JSA ace - Americai	n Indian.
5-0036	or Ita	þ	1 ☐ Never Married 2 ☐ Married 3 🖪 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cubar	Specify:	to Rican, etc.)		lack, White, et	c.
5-0		eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa kind of work done d	uring most of we	rking	16b. Kind of	Business/Indu	· · · · · · · · · · · · · · · · · · ·
2121	within iene. than	Completed	Elementary/Secondary (0-12) 8 1H GRADE	College (1-4or 5+)	NURS	DO NOT use retired)			HOSPIT	ΠAL	
Maryland	d la d	To Be (17. Father's Name (First, Middle, Las	,				me (First, Middle MATTHEN	_	ame)	
lary	S S S		19a. Informant's Name/Relationship			ng Address (Street a	nd Number or R	ural Route Numb			Code)
	ges 1 and 2 it of Health if item 27 or other tru		GLORIA GLOVER 20a. Method of Disposition	(DAUGHTER)	lace of Dispo	SPADING sition (Name of		BALTO.	20c. Location	21215 n - City or Tow	n. State
mon.	0 0		1 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci	Hemoval from State	emetery, cřer KRISON	matory or other place	1	23.05	OWING		
Baltimore,	pernit. Page Department Important: ff any injury or once.		21. Signature of Funecal Service Lice		VA	Name and Address UGHN C • G 51 BAUD, N	S of Facility	FUNERAL	SERVICE		C3 , 140
			23a. Part 1. Enter the disease, or con- shock, or heart failure. List only	pplications that caused the death						A	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	. cerebros	Lason	plar ac	cidar	+			Onset and Death
	/Medical Examiner		Tooling in county	Due to (or as a conseq	uence of):	Cho 3	flor	0		2	make
	D #	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	uence of).	ioma c	T IUI	3		(CX	months
p	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
68760,	e	dicalE		d	201.00 01).						
		a a	IF FEMALE:								
Вох	ath ce attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3□	Ectopic pregnancy				ate of delivery Month D	ay Year
P.O.	that the de ed by the detached	hysic	1 ☐ Yes 2 L No 9 ☐ Unknown	4∏Pregnant at time of d 9☐ Unknown	eatn 5	Other (specify)					•
	se us	by P	Part II, Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause give	n in Part I.				cause of death?
ord	v requir been si should I	eted						-			oly 4 □Unknown
of Vital Records,	elan has	Completed						24a. Was autor perfo	psy ormed?	prior to comp death?	y findings available pletion of cause of
ital	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath Check on o	2 No	1 ☐ Yes 2	□No
of V	Physician: this certific ral director,	P	examiner? 1 ☐ Yes 2 🔯 No		ER/Outpatien		4 Li Nursing F	fome 5 K Resi			
on (ding After fune	tion;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? es 2 □ No	28d. Describe	how injury occa	rred	
Division	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 Could not to determined	OP Disco of lawy At he	me, farm, str			28f. Location (: City or Tox	Street and Nun	nber or Rural F	Route Number,
Ō	spital or Al ours after o taral Dirac filled in by										
	To the Hosp within 24 ho To the Fune completely fi	edical	29a. Certifier (Check only one) Certifying P 2 Medical Exa	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my opi	e, date and place inion, death occu	e, and due to the irred at the time,	cause(s) and n date and place	nanner as state , and due to th	ed. ne cause(s)
	To th within To th compl	Me	29b. Signature and hitle of certifier	M.D.A		29c. License	number		29d. Date sign	ed (Month, Da	y, Year)
•	1		1 Vander	redu MI.)	D5	894		9/2	-105	
	V		30. Name and address of person who	completed cause of death (Item	23a) (Type. 240	Print) 1 W Bell	redere	Avel	Baltin	nove 1	1D
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9	2005 32. Rigistrar's Signa	tura /	1346				2/2/2	7

	1	For State Registrar	State of Maryland		nt of Health and te of Death		iene
Physicia /Medica Examine	n il -	Decedent's Name (First, Middle OALFER Ja. Facility Name (If not institution Saint Joseph	P. DIXON		Town, or Location of Dea		Day Year
Funeral Director		5. Social Security Number 2/9-38-0368 Jual Residence of Decedent	6. Sex 7. Age (In yrs. last		er 1 Year If Under 24 Hr	8. Date of Birth	
he Maryland 28a-f ehow otilijed at	.	10a. State 10b. County		own or Location	C ip Code		10d. Inside City Limits 1 ☐ Yes 2 ☑ No 0g. Citizen of What Country?
iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland aritment of Heath and Mental Hygiene. ortant: if item 27 is marked other than "natural; or iteme 23a or 28a-f ehow injury or other traumatic event, the Mcdical Exandrar must be mutified at	ia C	3/04 ORK	12. Was Decedent Ever in U.S. Amee Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		2 /222 edent of Hispanic Origin? (ecrify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc. Specify: White
e filed within 72 hour il Hygiene. other than "natural vent, The Medical Ex	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	('s Education 1 of grade completed) 1 College (1-4or 5+)		ork done during most of we use retired) Sab/	orking	16b. Kind of Business/Industry
2 should be filed with and Mental Hygiene, is marked other than sumatic event, here	lo Be	17. Father's Name (First, Middle, LEROY 19a. Intermant's Name/Relations	NON	19b. Mailing Addres	Ma	ime (First, Middle, 1 Pha - Tural Route Number	
Pages 1 and 2 nent of Health s int: if item 27 is	-	20a. Method of Disposition	3 □Removal from State ceme	3/04 e of Disposition (Na etery, crematory or	ame of other place)	Date	2/222 20c. Location - City or Town, State
permit. Page Department o important: if any injury or once.		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	Licensee	27	and Address of Facility 34 W 110W	TON FUNG	eral Home, P.A.
Physician /Medical Examiner popularitansi	miner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to initivation cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Mycar Due to (or as a consequent) Congestive I Due to (or as a consequent) Due to (or as a consequent)	rdial Ir nce of): Heart Fa	nfarction	ac or respiratory and	Approximate Interval Between Onset and Death Days Pars
	/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic			23d. Date of delivery Month Day Year
requires that een signed bi nould be deta	2		ons contributing to death but not resultin		cause given in Part I.	23e. Did tot	pacco use contribute to the cause of death? es 2 X No 3 ☐ Probably 4 ☐Unknown
ificate has been signs or, page 2 should be	e Completed	25. Was case referred to medica			26 Place of De	24a. Was a autops perform 1 Yes 2	y prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 X No
tending Physicii leath. tor: After this ceri the funeral direct	0	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pendir 2 Accident investi	Hospital: 1 Inpatient 2 ER. 28a. Dale of Injury (Month, Day Year) 28	VOutpatient 3 C Bb. Time of Injury	Other	Home 5 ☐ Reside	ence 6 Other (Specify) ow injury occurred
pital or Atte ours after dea eral Director	Il Certification:	3 Suicide 6 Could 4 Homicide determ				City or Towr	
	Medical	29b. Signature and title of certifie	Examiner: On the basis of examination and manner stated.	n and/or investigation	n, in my opinion, death occ	curred at the time, d	ate and place, and due to the cause(s) 9d. Date signed (Month, Dey, Year) 2eptluber 27,2005
Stat Registra	e	30. Name and address of person Abdallah J. H 31. Date filed (Month, Day, Year)	32/. Registrar's Signature	ii Osler	Drive Tox		ryland 21204

DHMH 17 Rev 1/2001

		-	State of Maryland / Departm	nent of Health and Ment		2005 31607
	Physici	2	Registrer 1. Decedent's Name (First, Middle, Last)	2. D	Date of Death	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b.	SEI City, Town, or Location of Death		27,2005 8:06P. M
7	Examin	٠,	6708 GERMAN HILL ROAD B	ALTIMORE		
*.	Funeral Director			inder 1 Year If Under 24 Hrs. 1 Days Hours Min.	pate of Birth Month, Day, Year) Têh 19, 19	9. Birthplace (State or Foreign Country)
	ryland show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 (Des 2 □ No
	death with the Maryland ims 23a or 28a-f show r must be notified at	Funeral Director		OCC f. Zip Code	10a. Cit	izen of What Country?
	th with	al Di	6708 German Hill Rd.	21222		USA
	Items ner m	uner	11. Marital Status 12. Was Decedent Ever in U.S. If Yes 1 Never Married 2 Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1	Decedent of Hispanic Origin? (Specify N specify Cuban, Mexican, Puerto Rican	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	72 hours after natural', or Ite	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	es 2 No Specity:		Specify: White
15-0	in 72 h	Completed	(Specify only highest grade completed) (Give kind life, DO N	Usual Occupation of work done during most of working OT use retired)		ind of Business/Industry
2121	filed within Hygiene. ther then ont, the Mar	Com		ock Clerk		quar Business
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene the Health and Mental Hygiene Them 23 is marked other then "natural", or Items 23s or 28s-1 show than traumatic event, the Medical Examinar must be notilised at	To Be	17. Father's Name (First, Middle, Last) VINCENT A. DERWINIS	18. Mother's Name (Firs	and the last of th	
Man	nd 2 sho alth and 1 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad 4027	dress (Street and Number or Rural Rou	ute Number, City o	or Town, State, Zip Code)
altimore,	Pages 1 a nent of Hes nt: If Item iry or otha	To the	20a. Method of Disposition 1	(Name of Date) or other place)	20c. Le	ocation - City or Town, State
Balti	permit. Page Department of Important: If eny injury or once.		Cherry Care	ne and Address of Facility Address of Facility Address of Facility	-UNERA	1 Home, P.A. 1. 21222
Y 34			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or res	piratory arrest,	Approximate interval Between Onset and Death
9	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	aprilic and	unis	m
8	Examiner)	
<i>'</i> 4/	red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•		
60,7	be executed ician and burial-transit		that initiated events c. Due to (or as a consequence of):			
6876	icate b physic s the bi	edicai	d			
Вох	that the death certificate be exed by the attending physician detached for use as the buria	lan/Me		pic pregnancy	1	23d. Date of delivery Month Day Year
P.O.	the de by the a ached f	hysic	1 Yes 2 No 4 Pregnant at time of death 5 Oth 9 Unknown	er (specify)		
	Se CB 90	Completed by Physician/Med	Part II. Dther significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		use contribute to the cause of death?
Vital Records,	aw is b	nplet			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal F	The ate	0	25. Was case referred to medical	26. Place of Death (Chi	Yes 2□No	
of Vi	S S D	ToB		DOA Other: 4 Nursing Home	5 🗌 Residence	6 XOther (Specify) SCENE
ono	th. : After t	tlon:	27. Manner of Death Natural 5 Pending (Month, Day Year) Accident investigation	Work?	Describe how inju	ry occurred
Division of	or Atter after dea Director in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)		ocation (Street ar City or Town, State	nd Number or Rural Route Number, e)
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ 2 Madical Examiner: On the basis of examination and/or investigated and manner stated.			
	To the within To the comple	Me	29b. Signature and title of cerumer	29c. License number OCME	29d. Da	te signed (Month, Day, Year)
	•		MICHAN IVI			MBER 28,2005
	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Pring	11 Penn Street Ba	altimore	, Maryland 21201
*	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 9 2005			

			1 - For State Registrar	State of Maryland	d / Depa		ealth and M	lental Hygie	-	31608	
			1. Decedent's Name (First, Middle, Last)			. 2		2. Date of Death		3. Time of Death	
	Physic /Medi		JOHN			DENTON		SEPTEMBER 27 200		4:21 A M	
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death		
		4	HARBOR HOSP	ITAL CENTE	R	BALT	MORE		N/A		
	- Funeral Director	83	234 32 0311	7. Age (In yrs. In 80	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) April 20	9. Birth Cor , 1925 Wes	place (State or Foreign intry) t Virginia	
	J within 72 hours after deeth with the Maryland jelene. rthen "natural", or Iteme 23a or 28a-f show triben "natural", or Iteme 23a or 28a-f show the Macifel Examinar must be neithful at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
			Maryland N/A	В	altimo	re				1X Yes 2 No	
			10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntrv?	
			3711 St. Victor	Street		212	25		U.S.	ŕ	
			11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - Amer		
9	or It	F	1 ☐ Never Married 2 🛣 Marned	1 K∑Yes 2 □ No If Yes, Give WW II Year or Dates: WW II		1 ☐ Yes 24€ No Specify:		rican, etc.)		Black, White, etc. Specify: White	
21215-0036	ural',	d by	3 Widowed 4 Divorced						Specify: Whi		
5	"nat	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of work	ing 16	6b. Kind of Business/fi	ndustry	
12	within ene. then "	m.	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		roader	1		estern MD.	Railroad	
9	Physicien: The law requires that the death certificate be executed X X Department of Health and Manial Hygin and Annial Hygin		17. Father's Name (First, Middle, Last)		Kall		18. Mother's Name	e (First, Middle, Ma		RUIIIONA	
Baitimore, Maryland		To Be	John Newton Denton Ida Bell								
		Physician/Medical Examiner	19a. Informant's Name/Relationship (Ty, Annie Denton / Wi	fe	3711	St. Victo	r Street	Baltime	Oity or Town, State, Zi ore, Mary1	and 21225	
			20a. Method of Disposition 1			sition (Name of natory or other place			c. Location - City or T		
Ē			4 ☐ Donation 5 ☐ Other (Specify)	G1e	n Have	n Mem. Pa	rk 9/30	/2005 G1	en Burnie	, Maryland	
39			21. Signature of Funeral Service License	90					al Service		
			Janua 19	raminous	40	OI Kitchi	le Highwa	y Baltin	nore, Maryl	land 21225	
			Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Due to (or as a consequence of): APTER Subden CARDEDRESPIRATORY Due to (or as a consequence of): Due to (or as a consequence of):							
Box 68760,			that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan	death 3	Ectopic pregnancy			23d. Date of deliv	23d. Date of delivery Month Day Year	
P.0.			1 Yes 2 No 9 Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (specify)			World	Day I Bai	
rds, F	equires that en signed ould be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
ec c	n: The law re ficate has be or, page 2 sho	piet	PERSPHERAL	VARCULAR	DS	EASE	CHRONE	24a. Was an	24b. Were auto	psy findings available mpletion of cause of	
tat Re		e Completed	FDNEY DESE	ASE, ATRI		FIBRIL	ATTON	performer	d? death?		
>	ysicie s cert direct	To B	examiner?	ospital: 1 €Inpatient 2 ☐ E	B/Outpatien		26. Place of Death		a G DOther (S-1)		
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after deadth. within 24 hours after deadth. to the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Comparison							
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					al Route Number,		
		edicai (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the Comp	Me	29b. Signature and title of certifier	_		29c. License	number	29d.	Date signed (Month,	Dey, Year)	
			Harut GER	SRTWOLD (M-D"	10	100	SE	PIEMOTO "	12- 2005	
	"X,		30. Name and address of person who con	_					MISERO	E, M2 2125	
	1,		HERUT GEBERN		001 5		IANDVE	R ST	BALTMOR	E, MD 21221	
14	Sta	1.004	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ле						
A	Registr	ar	SEP 2 9 2005	Homes H.	1034	120					

DHMH 17 Rev 1/2001

		,	1- For State of Maryland / Depa	rtment of Health and M tificate of Death		2005	31609
			Registrar 1. Decedent's Name (First, Middle, Last)	imodio or Bodin	2. Date of Death	J. No.	3. Time of Death
	Physici		Kathy Ann Davis		Month Septembe	Day Year	M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Depeanoe	r 21, 2005 4c. County of Death	00.05
			Upper Chesapeake Medical Center	Bel Air		Harfor	db
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 10,	9. Birth	place (State or Foreign ntm) Yland
	Director		218-42-8680		July 10,	1945 Mar	yrand
	yland		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
	a-fet	ctor	Maryland Harford Forest Hi	.11			1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	ntry?
	s 23a	rai	305 Willrich Circle, Unit C	21050		USA	and lastice
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or Items 23a or 28a-f ehow event, tre Modical Exercilier: anst be ricitified at	by Funeral Director	A mod Forces? If 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto Yes 2 XNo Specify:	ecry Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2-0	72 hc	etec	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of worki	ng 16	6b. Kind of Business/Ir	ndustry
121	within sne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Tra	on NOT use retired)	F	ederal Gov	ernment
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	18. Mother's Name			eriment
au	id be ental ked o ic eve	To Be	Lawrence Hampton Lauer	Katherin		Ray	
Maryland	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 le marked other then or other treumetic event, Ir.e.Ms.	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address (Street and Number or Rura	al Route Number, (City or Town, State, Zij	c Code)
	P = N =			Willrich Circle, U	The second second second		
ore	Pages 1 nent of H int: If iter		1 Duriai 2 Cremation 3 Ememoval noncotate 1	natory or other place)		Oc. Location - City or T	
Baltimore,	t. Pa rtmen rtent: njury				24/05	Bel Air,	
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		> Helle // (mas to	1317 Cokesb	oury Road		
	Pnysician	er 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart allule. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death)	ENCEPHALOP			Interval Between Onset and Death
j,	/Medical Examiner		Due to (or as a consequence of):	te ARRYTHIN	uA.		
50		je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).	TE MERTITIE	7771		
V	the burial-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ARY ANTER	1 DISE	ASE	30yrs -
8760,	oe exectan a	i Ex	resulting in death) Last Due to (or as a consequence of):	41511171			•
876	cate to physic the b	dicai	d. DIABET	TES MELLITIS	•		
.O. Box 6	the death certificate be executed y the attending physician and Iched for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
<u>α</u>	⇒ > 3	, Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ds,	as mg	d by	f 1. 77.15= 11-07	PAILURE	1 ☐ Yes	2 ∆ Mo 3 □ Prof	pably 4 Unknown
COL	w requires been si	ojete	RENAL PAILURE		24a. Was an	24b. Were auto	ppsy findings available
Vital Records,	e - e	Completed	MORBID OBESSITY	4	autopsy performe 1 Yes 2	prior to co	mpletion of cause of 2 No
ta	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death		No 1L Yes	20140
	8 S E	Tof	1 ☐ Yes 2 ☐ No Hospital: I ☐ Impatient 2 ☐ ER/Outpatient		me 5 ☐ Residend	ce 6 Other (Special	(y)
Division of	ing After	ion:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
isio	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	28f. Location (Stre	et and Number or Run	al Route Number
Ω	# # # E	Certification:	4 Homicide determined building, etc. (Specify)	ot, radiory, difficu	City or Town, .	State)	
	To the Hospitel or At within 24 hours after C To the Funeral Direct completely filled in by	edical C		occurred at the time, date and place, a estigation, in my opinion, death occurred	and due to the cau ed at the time, date	se(s) and manner as s e and place, and due t	stated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	290	1. Date signed (Month,	Day, Year)
}			Muchano Hood Mo	. DL1080	(9/21/2	005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, F	KLYNILLE Rd.	BELA	12 Md	2014.
	Sta Regista		31. Date filed (Month, Day, Year) SEP 2 9 2005 SEP 3 9 2005	early s		7-12-1	1
	riogiot	100	OLINOLOUS REALIST AS AB				

DHMH 17 Rev 1/2001

338

125

Suzanne Davis 05-04248 d1

Funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tate of Maryland	/ Department of Health and I	Mental Hygiene
	/ Department of Health and I Certificate of Death	Reg. No.

0	5	3	6	I	0
-	~	-	~		-

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funarai Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

cian							711110010 01	Death	1	Reg. Ñ	0.			
	1. Decedent's Name								2. Date of De Month	D	2 2005	Year		me of Dea
ical	Suzanne			t and numba			4h Chi Taur	and applies of Dool		_	2005	-4 D1	9:	+5 P
iner	4a. Facility Name (// 2328 Ocal		n, give stree enue	t and number	")		Baltin	or Location of Deat	n	4	c. County	or Dear	n	
	5. Social Security N		6. Sex	7.4	Age (In yrs. Ia	st hirthday			8. Date of Bir	th		Q Rie	hpiaga /	tata or Fo
	Usual Residence of	unk	1 M		78	Yrs.	Months Days		Apr 24	Year	927	Go.	untry)	tate or Foi un
	10a. State	10b. County	,	-	10c. City,	Town or L	ocation						10d. Ins	ide City Lir
ō	MD				Bal:	timor	ore						118	Yes 2
Director	10e, Street and Nur	mber	-		Dai	CIMOL						Vhat Co	untar2	
			nue				21203					viiat 00		unk
Funerai	11. Marital Status	unl	A .	Vas Deceden Armed Forces	nt Ever in U.S \$?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						e - Ame k, White	rican Indi a. etc.	an,
þ	3 Widowed		ned 1	☐ Yes 2 ☑ f Yes, Give ∕ear or Dates	₫No ::		1 ☐ Yes 2 ☑ No Specify:						ack	
Completed	(Spec	15. Deceden cify only highes	it's Educationst grade cor	n npleted)		(Give	dent's Usual Occu	e during most of wo.	rking	16b. l	Kind of Bu	ısiness/	Industry	
m d	Elementary/Seco	ondary (0-12) unk	C	College (1-40)	r 5+) ink	IIfe.	life. DO NOT use retired)							1.
			Last)	U	IIIK		unk 18. Mother's Name (First, Middle, M					e)		unk
To Be		,					unk		(r mai, middle	,arud	. camaii	.5,		unk
	19a. Informant's Na	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St.												
	O.C.M.E. 111 Penn Street Baltimore, Maryland 21								2120	1				
	1 🗆 Burial 2	20a. Method of Disposition 1												
	21. Signature		_	11/1	rector	ŝ	2. Name and Addi tate Ana	ress of Facility Lomy Boar MD 2120	d 655 W	. Ba	1tim	ore	Stre	ρt
	N	1000	11/1	well		В	altimore	, MD 2120	Ι "			OIC	Dere	
i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence d.										_			
100														
edica			d											
nysician/Medical	IF FEMALE: 23b. Was deceden in the past 12, 1 □ Yes 2 0, 9 □ Unknown	months?	1	Live birth	ie of pregnan 2	death 3	⊒Ectopic pregnan ⊒ Other (specify)	су			23d. Dati Mor		very Day	Year
by Physician/	23b. Was deceden in the past 12, 1 ☐ Yes 2 € 9 ☐ Unknown	Months?	1 4 9	I □ Live birth I □ Pregnant I □ Unknown	2 ∏Fetal o at time of dea	death 3[ath 5[Other (specify)		23e. Did t	obacco Yes 2	Mor	nth	Day	
by Physician/	23b. Was deceden in the past 12, 1 ☐ Yes 2 € 9 ☐ Unknown	Months?	1 4 9	I □ Live birth I □ Pregnant I □ Unknown	2 ∏Fetal o at time of dea	death 3[ath 5[Other (specify)		1 🗆 '	Yes 2 an	Moruse contr	nth sibute to 3 Pro Vere authorior to coleath?	Day the caus bably topsy finc	e of death' Unknownings availa
Completed by Physician/	23b. Was deceden in the past 12. 1 □ Yes 2 €. 9 □ Unknown Part II. Other signit	, months? X No ficant condition	ons contribu	I □ Live birth I □ Pregnant I □ Unknown	2 ∏Fetal o at time of dea	death 3[ath 5[Other (specify)	iven in Part I.	1 1 24a. Was autopento	an osy ormed?	Moruse contr	nth sibute to 3 Pro Vere authorior to coleath?	Day the caus bbably topsy find	e of death' Unknownings availa
Be Completed by Physician/	23b. Was deceden in the past 12, 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other signif	rred to medical	ons contribu	□ Live birth □ Pregnant □ Unknown Iting to death	2 Fetal c	death 3[Other (specify)	iven in Part I. 26. Place of Dec	24a. Was autor performed 1 yes ath (Check only control of the cont	an osy ormad?	Moruse contr	ibute to 3 Pro Vere authorior to cleath?	the causobably topsy find ompletion	e of death' Unknownings availated to cause
To Be Completed by Physician/	23b. Was deceden in the past 12, 1 □ Yes 2 0, 9 □ Unknown Part II. Other signif 25. Was case refer examiner? 1 ▼ Yes 2 □ 27. Manner of Deat 1 ▼ Natural	rred to medical	ons contribu	□ Live birth □ Pregnant □ Unknown Iting to death	2 Fetal cat time of dea	death 3[ath 5[other (specify) underlying cause g nt 3 □ DOA O	26. Place of Deather: 4 \(\text{Nursing Harry at ork?} \)	1 1 24a. Was autopento	an osy ormed? 2 No	Moruse contr	onth 3 Pro Vere author to cleath? Pres Yes	the causobably topsy find ompletion	e of death' Unknownings availated to cause
To Be Completed by Physician/	23b. Was deceden in the past 12, 1 Yes 2 9 Unknown Part II. Other signif	rred to medical	ons contributed to the second	tal: 1 Inpal Ba. Date of In (Month, D)	2 ☐ Fetal cat time of deal but not result but not result tient 2 ☐ E jury lay Year)	Jeath 3 [ath 5 [ting in the unit of the content	other (specify) underlying cause g nt 3 □ DOA O	26. Place of Deather: 4 □ Nursing Hury at ork?	24a. Was autop performed autop performed ath (Check only of lome 5 - Resident)	an psy imad? 2 None) dence how inju	Moruse control No 24b. V P D 1 6 COther	Nere autorior to cleath? Yese ar (Specied	the caus bbably topsy find ompletion 2 \(\text{No.} \) No.	e of death' Munknotings availated to cause
Certification: To Be Completed by Physician/	23b. Was deceden in the past 12, 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other signife 25. Was case refer examiner? 1 ★ Yes 2 ☐ 27. Manner of Deat 1 ★ Natural 2 ☐ Accident 3 ☐ Suicide	rred to medical No th 5 Pendin investig 6 Could in determ	ons contributed to the second of the second	tal: Impal 2 Fetal cat time of deat time o	seath 3 [ath 5 [ath 5 [ath 5 [ath 5 [ath 5]]]] R/Outpatier 28b. Time conjury ne, farm, stolledge, deat	other (specify) Int 3 DOA of 28c. Int With M 1 Creet, factory, office	26. Place of Deather: 4 □ Nursing Hury at ork?	24a. Was autop performent of the control of the con	an an an an an an an an an an an an an a	Mor use contr \(\text{No} \) 24b. V \(\text{P} \) d \(\text{Other} \) 6 \(\text{Cother} \) Other ry occurred a) and Mumber a)	ibute to 3 Pro Vere autrior to celeath? Yes ar (Speceed	the caus bably topsy find ompletion 2 \(\text{No.} \) No call Route stated.	e of death' 4 XUnknow ings availated of cause ene Number,	
To Be Completed by Physician/	23b. Was deceden in the past 12, 1 Yes 2 0 9 Unknown Part II. Other signif 25. Was case refer examiner? 1 Xes 2 2 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide	rred to medical rred to medical No ficant condition red to medical No th 5 Pendin investic 6 Could r determ 1 Certifyin 2 Medical	ons contributed to the second of the second	tal: 1 Inpal Ba. Date of In (Month, D Be. Place of In building, 6	2 Fetal cat time of deat time o	seath 3 [ath 5 [ath 5 [ath 5 [ath 5 [ath 5]]]] R/Outpatier 28b. Time conjury ne, farm, stolledge, deat	other (specify) Int 3 DOA of 28c. Inju W M 1 Creet, factory, office	26. Place of Deather: 4 Nursing Hury at ork?	24a. Was autop performent of the control of the con	yes 2 an osy ormed? 2 (No one) dence how inju Street aa wn, State cause(s) date an	Mor use contr \(\text{No} \) 24b. V \(\text{P} \) d \(\text{Other} \) 6 \(\text{Cother} \) Other ry occurred a) and Mumber a)	nth sibute to 3 Province Authority Province Auth	Day the caus bbably topsy finc ompletion 2 \(\text{No} \) No ral Route stated. to the ca	e of death' 4 AUnkno ings availa in of cause ene Number,
edical Certification: To Be Completed by Physician/	23b. Was deceden in the past 12, 1 Yes 2 0 9 Unknown Part II. Other signif 25. Was case refer examiner? 1 Yes 2 27. Manner of Deat 1 Matural 2 Accident 3 Suicide 4 Homicide	rred to medical rred to medical No ficant condition red to medical No th 5 Pendin investic 6 Could r determ 1 Certifyin 2 Medical	ons contributed to the second of the second	tal: 1 Inpal Ba. Date of In (Month, D Be. Place of In building, 6	2 Fetal cat time of deat time o	seath 3 [ath 5 [ath 5 [ath 5 [ath 5 [ath 5]]]] R/Outpatier 28b. Time conjury ne, farm, stolledge, deat	other (specify) Int 3 DOA of 28c. Inju W M 1 Creet, factory, office	26. Place of Deather: 4 Nursing Hury at ork? Yes 2 No	24a. Was autop performent of the control of the con	an psy immed? 2 No none) dence how injured street anwn, State cause (state and 29d. De	Mor use contr No 24b. V p d d 1 6 Cother ry occurre and Number e)) and mai	Nere authoritor to coleath? Yes Yes Yes Yes Yes Yes Yes Ye	the cause bably topsy find ompletion 2 \(\text{No.} \) No. No.	e of death' 4 AUnkno ings availa in of cause ene Number,
edical Certification: To Be Completed by Physician/	23b. Was deceden in the past 12, 1 Yes 2 0 9 Unknown Part II. Other signif 25. Was case refer examiner? 1 Yes 2 27. Manner of Deat 1 Matural 2 Accident 3 Suicide 4 Homicide	rred to medical rred to medical No 5 Pendin investig 6 Could related to title of certifien	Hospi ggation not be nined 28	tal: 1 Inpat Ba. Date of In (Month, D) Be. Place of It building, e on: To the besis and manner's	2 Fetal cat time of deat time o	P/Outpatiei 28b. Time c Injury	other (specify) Int 3 DOA of 28c, Ini M 1 Creet, factory, office th occurred at the investigation, in my 29c, Licer OCI Print)	26. Place of Deather: 4 Nursing Hury at ork? Yes 2 No	24a. Was autop performent of the control of the con	an an and an an an an an an an an an an an an an	Mor use contr Use contr No 24b. V O 1 6 Cothe ry occurre and Number a) and mand d place, a	Note to a light of the state of	the cause bably topsy find ompletion ompletion of the cause of the cau	e of death' 4 XUnknot ings availa n of cause Number, use(s)

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 22, 2005 **Physician** Year Jean Grace Delvecchio 2:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Center Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F Months 68 Director 219-32-7020 May 25, 1937 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Itam 27 is marked other than "naturel", or itams 23a or 28e-f show other traumatic event, the Modical Examiner must be notified at MD Maryland Rosedale 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 U.S.A. Funeral 813 Sagramore Road 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 NWidowed 4 □ Divorced Specify: White Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hyglene. ant: If Itam 27 is marked other than "natural", ury or othar traumatic event, Ir a Maclical Exa-16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Mason Gennie Cannavo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Schmitt/daughter 3833 Bayville Road Baltimore, Maryland 21220 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Gardens of Faith 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9/26/05 Rosedale, Maryland 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Secret Livensee 1211 Chesaco Avenue Rosedale, MD 21237 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRUCFIVE **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transit 60 resulting in death) Last physician Box 68760 PEMENTIA Physician/Medical use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 2 No 1 Yes : After this certification : After this certification : To the Hospital or Attanding Physicien: Be 25. Was case referred to medical 26. Place Death Check onl one examiner' Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) lace SEP 2 9 2005 32. Agistrar's Signature State Registrar

				For State Registrar	State of Maryland	d / Depa		Health and M	lental Hyg	_	
•		Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, L Roland Fair 4a. Facility Name (If not institution, gi	Ford ive street and number)		4b. City, Town,	or Location of Death	2. Date of Dea Month September	ath Day	Yeer 3. Time of Death 2005 0940 A M
		Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. It		If Under 1 Year Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day Dec. 20	, Year) 1951	9. Birthplace (State or Foreign Country) Maryland
		hours after death with the Maryland turst, or items 23s or 28s-1 show at Examiner must be multiped at	ector	10a. State 10b. County MD Carrol		Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 🕱 No
		with the	Dire	10e. Street and Number 4241 Buffalo Roa	.a		10f. Zip Code 21771		ŀ	10g. Citizen of	*
		death w	eral	11. Marital Status	12. Was Decedent Ever in U.S	5. 13. W		Hispanic Origin? (Spe		United 14. Bac	ce - American Indian,
	900	ours after death v iral', or items 23s	d by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates:		Yes, specify Cul	Hispanic Origin? (Spe ban, Mexican, Puerto o Specify:	Rican, etc.)	Blac Specif	ck, White, etc.
AND	1215-(within 72 hours ane. than "natural", he Medical Ex	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decede (Give k life. De Draft		pation during most of workingd)	ng	16b. Kind of B	usiness/Industry
, RELAND	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene important: If item 27 is marked other than "natur any injury or other treumatic event, the Medical ance.	To Be Co	17. Father's Name (First, Middle, Las Dean Joseph Ford		Diaic	Silidi	18. Mother's Name		Maiden Suman	
TORD,		and 2 shore ealth and N m 27 is mans		19a. Informant's Name/Relationship Margaret F. Ford	l Wife	4241	Buffalo	t and Number or Rura Road Mt.	Airy,		
	Baltimore,	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	South	th Carr	tion (Name of atory or other pla coll Cre	ematory 2	005	Winfie]	
	Bal	Dermi Depa Impo any ir		21. Signature of Funeral Service Lice	Coller	12	12 W. O.	ld Liberty	Road I	Winfiel	
	V	Physician /Medical Examiner policy po	Examiner	29a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	ence of):			Tophatory and	631,	Approximate Interval Between Onset and Death 20 YEAV25
		ath certificate ttending phy or use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de:	icy death 3⊟E	ctopic pregnanc Other (specify)	у		23d. Dat	te of delivery nth Day Year
	s, P.O.	res that the de. igned by the a be detached f	by Phys	9 Unknown Part II. Other significant conditions	9□ Unknown contributing to death but not resul	iting in the und	erlying cause gr	ven in Part I.	23e. Did tob	pacco use conti	ribute to the cause of death?
	ord	w require been sig		OBESITY					1 1	es 2 🗆 No	3 Probably 4 Unknown
	I Rec	The taw ate has b bage 2 s	Completed	COPD MELLI	TUS				24a. Was a autops perform	ned?	Were autopsy findings available prior to completion of cause of death?
	Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1 -	26. Place of Death	Check only on	е)	
	Division of Vital Records,	ding Phye h. After this funeral dir	ıtlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Inju	ner: 4 Nursing Hom ry at 2 rk? Yes 2 No	ne 5 Reside 8d. Describe ho		
	Divis	2 5 5 6	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	t, factory, office	2	8f. Location (St. City or Town	reet and Number, State)	er or Rural Route Number,
		To the Hospitel or Al within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifyin Pl (Check only one) 2 Medical Example	hysicien: To the best of my know miner: On the basis of examinatio and manner stated.	on and/or inve	scured at the trestigation, in my o	me date and place, a opinion, death occurre	nd due to the da d at the time, da	lusa(s) anda. ate and place, a	and due to the cause(s)
		To To	Σ	29b. Signature and title of certifier	Commen		29c. Licens			-	(Month, Day, Year)
		1	1	Putw W. Cux 30. Name and address of person who		22a) /Tur= P		1129		iertembe	er 27, 2005
		5		PETER W. CHO	Sinai Hospita	1	Raiti	more, MD	21215		
		Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2	005 32 Registrar's Signatu	To Jos	de				

		Registrar 2000 2000	partment of Health and Mer Princatener GHAh10-13-	US LEIPING. N	No.
Physici /Medio	an al	JEFFREY LOUIS	FRIEDMANN	Month C	26, 2005 11:45 A ^M
) Examir	er	4a. Facility Name (If not institution, give street and number) 3615 FORUS LANE APT. 211	4b. City, Town, or Location of Death BALTIMORE CITY	,	4c. County of Death N/A
, Funeral Director		5. Social Security Number 214-68-0764 6. Sex 1 M 2 F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. 11	Date of Birth (Month, Day, Yea /22/1954	9. Birthplace (State or Foreign Country) MD
Maryland -f ehow lied at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
vith the Maryla or 28a-f ehor	ctor	MD N/A BALTI	MORE		1 🏹 Yes 2 □ No
with the	Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
death y	Funerai	3615 FORDS LANE APT. 211 11. Marital Status 12. Was Decedent Ever in U.S. 13	21215 3. Was Decedent of Hispanic Origin? (Specify	y Yes or No-	U.S.A.
d within 72 hours after or giene. er then "natural", or Iten the Medical Exeminer.	by	1 Never Married 2 Married 1 Yes 2 No If Yes, 2 No If Yes, 6 Ne Year or Dates:	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 No Specify: 	an, etc.)	Black, White, etc. Specify: WHITE
72 hc	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of working	16b.	Kind of Business/Industry
be filed within 72 hr tal Hygiene. d other then "natu	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)	Δ	UTO SUPPLY
, Ette	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
ould be Mental arked o	ToB	DONALD FRIEDM	ANN ANITA		RASKIN
2 2 30 30			iling Address (Street and Number or Rural Re	oute Number, City	or Town, State, Zip Code)
			19 GROFFS MILL #OAD		MILLS, MD 21117
ages ont of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, ca	ematory or other place)	200.	Location - City or Town, State
permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		21. Signature of Funeral Semice Licenside		LEVINSON	& BROS., INC.
*		23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	8900 REISTERSTOWN ROUNTED THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF THE MODE OF T	AD - PIK espiratory arrest,	ESVILLE, MD 21208 Approximate Interval Between
Physician /Medical Examiner	ner	Immediate Cause (Finat disease or condition resulting in death) Atherosclerotic C Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	ardiovascular Diseas	e	Onset and Death
death certificate be executed e attending physician and of for use as the burial-transit	sal Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):			
tificate ng phys as the	ledical	· ·			
	Physician/M		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of defivery Month Day Year
• ਵੇਂ ਰੂਥ	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
The law ate has b page 2 si	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death C		
nding Phys tth. :: After this e funeral dii	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 1 Inpatient 2 ER/Outpati	of 28c. Injury at 28d.	5 ☐ Residence Describe how in	6 XOther (Specify) AT SCENE ury occurred
To the Hospitel or Attender within 24 hours after to the Funerel Directors completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
he Hospil in 24 hour he Funere pletely fille	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(it the time, date ai	s) and manner as stated. nd place, and due to the cause(s)
To 1 To 1	×	29b. Signature and title of certifier Pollok	29c. License number O.C.M.E		ate signed (Month, Day, Year) EPT. 27, 2005
		30. Nurse and address of person who completed cause a death (Item 23a) (Typo 1111 PEN 31. Date filed (Month, Day, Year)	N STREET, BALTIMORE,	MARYLAND	21201
Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2005 32. Registrar's Signature	foods		

			State of Marylar	nd / Departmo <i>Certific</i>			-	A	15 3	1611.
		1. Decedent's Name (First, Middle, Last))				2. Date of De	ath	3.	Time of Death
н	Physician	Rosa She	11,,			Griffin	Month Septem	ber 21,	Year 2005	6:00 Al
The st	/Medical Examiner	Rosa She					r Locetion of Death			5 1 0 0 14.
	Examiner	Millennium Health	& Rehab			Silver	Spring	Mont	gomery	
	Funeral	5. Social Security Number 6. Sex			nder 1 Year	If Under 24 Hr	S. 8 Date of Bir	th	9. Birthplace	(State or Foreign
	Director	578-44-4187]M 2 X)F	O Yrs. Mont	hs Deys	Hours Mir		4, 1914	Country) Virgin	ia
		Usual Residence of Decedent					, , , , ,			
	rylan ihow	10a. State 10b. County	10c. Ci	ty, Town or Location						nside City Limits
	Ba-f s	Maryland Montgomer	ry S	ilver Spr	ing					☐ Yes 2 🔯 No
	or 28	10e. Street end Number		10f.	Zip Code			10g. Citizen of V	Vhat Country?	
	uter death with the Marritems 23a or 28a-fa	2601 Bel Pre Road		20	0906			U.S.A		
	r deg	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was De If Yes, s	ecedent of Hi specify Cuba	ispenic Origin? (ın, Mexican, Pue	Specify Yes or No erto Rican, etc.)	- 14. Race Blac	e - American In k, White, etc.	idian,
20	or the	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give			Specify:		Specify		
8	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28s-f ahow the Medical Examiner must be notified at completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						втас	
5	led within 72 ho ygiene. for than "natura it, the Medical in	15. Decedent's Educ (Specify only highest grede	cetion e co <i>mpleted)</i>	16a. Decedent's L (Give kind of life. DO NO	work done o	durina most of w	orking	16b. Kind of Bu	ısiness/Industr	y
12	than "I the Med	Elementary/Secondary (0-12)	College (1-4or 5+)	Dome	_	"		Homema	le o se	
12	e filed v other t vent, ID	10 17. Father's Name (First, Middle, Last)		Dollies	SLIC	18 Mother's Na	ame (First, Middle,			
Maryland 21215-0020	be fill He fill He od out		Cr				e Wyatt	, maiden caman	0)	
Ž	J Meni	19a. Informant's Name/Relationship (Ty)		10h Malling Add	/Ctroot		Rurel Route Numb	os City os Tours	Stata Zin Cod	(0)
Ma	d2 sl h and h is n traur							•		9)
	Healt Sm 2	Alvera Griffin 20a. Method of Disposition	(Sister)	Place of Disposition (Name of		oucester	, VA 230 20c. Location -		State
و	ages if it	1 X Burial 2 ☐ Cremetion 3 ☐ R		cemetery, crematory Union Zio	or other plac					7.00
Baltimore,	it. Pertrant	4 Donation 5 Other (Specify)		Church Cer	metery	ss of Facility	9/26/05	Ware Ne	ck, VA	
Bal	permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other important: or other traumatic event, any injury or other traumatic event, ance. To Be C	21. Signature of Funeral Service License				uneral	Home			
	22.20	23a, Part1, Enter the disease, or compli	Fellmen				hington 1			, VA proximate
0	hysician end sthe burial-transit sthe burial-transit edical Examiner	shock, or heart failure. List only on Immediate Ceuse (Final disease or condition resulting in death) a	Cardiopulmo Due to (or as a consequence	of): Llure				Ons	rval Between set and Death
	execting an endial-tr	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	240 (0 (5, 45 4 56,155qu51150	0.7.					
68760,	cate be executed physician and sthe burial-transit edical Examil	Ceuse (Disease or injury that initiated events	Due to (c	or as a consequence	of):					
	20 00 00	resulting in death) Last			,-				İ	
Box	death certific e ettending p ed for use es	_ d	1		-					
	death e effe ad for	Part II. Other significent conditions con	tributing to death but not res	sulting in the underlying	ng cause give	en in Part I.	23b. Did	tobecco use con	tribute to the	ceuse of death?
P.O.	that the death certii ed by the ettending deteched for use e				-		1 🗆	Yes 2□ No	3 Probably	4 ⊠ Unknown
S, I	es that igned b be dete by PI	Dementia					-			
cord	s been s s should	Organic Brain	Syndrome				24a. Was perfo	an autopsy ormed?	available	utopsy findings e prior to tion of cause 1?
æ	The law te hes age 2	Enemia					10	Yes 2⊠ No	1 ☐ Yes	s 2□ No
Vital	entifice actor, p	25. Was case referred to medical				26. Place of De	eath <i>Check</i> only o	one)		
>	hysich his cer al direc	examiner? 1 ☐ Yes 2 ☒ No	lospital:	ER/Outpatient 3□	DOA Othe	er: 4X Nursing	Home 5 ☐ Resid	dence 6 □Othe	er (Specify)	
on of		27. Menner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at ⟨? Yes 2 □ No	28d. Describe I	how injury occurre	ed	
Division	tai or Attending P rs efter death. el Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	ctory, office		28f. Location (S City or Tox	Street end Numbe vn, State)	er or Rural Rou	te Number,
_	n 24 hours n 24 hours he Funeral plately filled		diction: To the best of my knowner: On the basis of examina							cause(s)
	thin Sthin Smpla	29b. Signature and title of certifier	and manner stated.		29c. License	e number		29d. Date signed	I (Month, Dav.	Year)
	F 3 F 8	· Brime	(Ch							·
	1			- 02a) /T D	D515	20		Septemb	er 21,	2003
•	5	30. Name and address of person who co		m 23a) (Type, Print) 8 Southerr	Αντα	SF #	310 Wachi	ington. 1	DC 2003	2
	CANA	Bahram Pishdad, M 31. Date filed (Month, Day, Year)	32. Registrer's Signa		. Ave.	D. H.	YIO MUSIII		2003	
	State Registrar	CED a a 2m		K down	K a					

DHMH 16 Rev 6/95

	1 - For State Registrar			epartment of F Certificate of		Re	GUU ZONO,	31615		
sician	Decedent's Name (First, Middle, La	,				2. Date of Death Month	Day Year	3. Time of Death		
edical	Mary Ellen O'Ro		agher	4h City Town	or Location of Death	Septembe	er 20, 2005			
miner	Peninsula regiona		Center		sbury	'	Wicomio			
eral	5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.			nplace (State or Foreign untry)		
tor	134 30 3142	1□M 2ÅF	45 Y	s. Months Days	Hours Min.	Feb. 5,	1960 New	Jersey		
ompleted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
ō	New Jersey Oce	an		y Township				1 Yes 2 □ No		
Directo	10e. Street and Number	an	Lace	10f. Zip Code		10	g. Citizen of What Co	untry?		
O E	1347 M. Street			087	31		U.S.A.			
Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	dispanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White			
by Fu	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	0	1 ☐ Yes 2 ☒ No	Specify:	o / mount, oto.)		hite		
		Year or Dates:	168 [ecedent's Usual Occur	nation		6b. Kind of Business/I			
Completed	(Specify only highest gr	rade completed) College (1-4or 5-		Decedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of word)	king	OD. KING OF BUSINESSY	ndustry		
EoX	12	College (1-407 54		ail Carrie	r	U	.S. Postal	Service		
Be	17. Father's Name (First, Middle, Las.				18. Mother's Nan	me (First, Middle, Maiden Sumame)				
10	Edward Wilczynsk	ci			Marie H	Ha11				
	19a. Informant's Name/Relationship	265		Mailing Address (Street				ip Code)		
	Jerry O'Rourke ((Son)	The second secon	47 M St.,]	Lacey Tow					
	1 Burial 2 Cremation 3		cemetery,	crematory or other plac	· ·		oc. Location - City or T	own, State		
	4 Donation 5 Other (Special Signature of Funeral Service Lice		4–05	Orange, NJ						
	21. Signation of diseases	2011	- 1	Vander Pla	at Memor	ial Home	mus, NJ 076			
edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to or as a	consequence of	r	Caupli	talion		Article (
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	1		23d. Date of deliv Month	very Day Year		
by Pt	Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death?				
						1 ☐ Yes	s 2 □ No 3 □ Pro	bably 4 Eun known		
Completed			<u> </u>			24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of		
Be	25. Was case referred to medical examiner?	Hospital				th Check only one				
-T	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury		atient 3 DOA Oth	4 Nursing H		ice 6 ☐Other (Speci	fy)		
Certification:	1 Natural 5 Pending	(Month, Day	Year) Inju	ury Wor		28d. Describe how	of the forty	lici		
fica	3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, farm	Hew 2 1	1	28f. Location (Stre	eet and Number of Run	al Reute Number		
erti	4 Homicide	building, etc.	(Specily)	mla.		City or Town,	State)	Corollston		
Medicai C	29a. Certifier 1 ☐ Certifying Pl (Clock only one) 2 M Medical Exa	hysician: To the best of miner. On the basis of and manner state	examination and/	death occurred in the tir or investigation, in my o	ne, date and place, pinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as s le and place, and due t	stated. to the cause(s)		
dis.	29b. Signature and title of certifier 29c. License number OCME 29d. Date signed (Month, Day, Year) September 21, 2005 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) The contract of the complete cause of death (tem 23a) (Type, Print) Penn Street Baltimore, Maryland 21201									
Me	1 Theodus	M. High	atolitem 23a) (T				*	1, 2005		

DHMH 17 Rev 1/2001

		For Stata	State of	Marylan					Mental Hy	-	2005	01010
\$ 20		Registrar 1. Decedent's Name (First, Middle	e. Last)		Cel	rtificate	OIL	Jealii	2. Date of D	Reg. Ng.	.005	3 5 6 6
Physicia		Thomas Gruber	. ,						Month Septem	ber 2	21, ^{Year} 2005	10:32 PM
/Medica		4a. Facility Name (If not institution		nber)		4b. City, Town, or Location of Death 4c. Cour					County of Death	
	- 1	Joseph Richey						more				
Funeral Director		5. Social Security Number 218–36–6463	6. Sex 1 M 2 □ F	7. Age <i>(In yr</i> s. 65	• • • • • • • • • • • • • • • • • • • •		Days	Hours Min		ay, Year)	Coun	lace (State or Foreign htry) 1and
pu &		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation					1	0d. Inside City Limits
death with the Maryland ms 23a or 28a-1 ahow rount be notified at	ō		ington	700.0		gersto	1777					1 ☐ Yes 2√☐ No
28a-	Director	MD Wash	ington		IIa	10f. Zip 0				10g. Citi:	zen of What Cour	ntry?
h with	a l	18601 Roxbury	Road			2	1740	6			USA	
oms ?	Iner	11. Marital Status	12. Was Dece Armed For	dent Ever in U		Was Decede	ent of His	spanic Origin? (Specify Yes or N no Rican, etc.)	0-	14. Race - Americ Black, White,	
36 s afte	by Funeral	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🕱 Divorced	If Yes Giv	θ		1 Yes 2	X No	Specify:				ite
hour stural	ed b		t's Education	ites:	16a. Dece	dent's Usual	Occupa	ition	unk	16b. Kir	nd of Business/Inc	dustry unk
215 bin 72 mark	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) Coltege (1	-4or 5+)		kind of work DO NOT use		uring most of wo	orking			, all
212 ed with giene for the	Com	8	0									
Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other then "natural; or traumatic avent, the Modified Exercitations."	Be	17. Father's Name (First, Middle,						18. Mother's Na	ame (First, Middle	e, Maiden	Sumame)	unk
ryla hould d Men marks	2	George Grul			19b Mailie	an Address (Street a	nd Number or P	Pural Poute Numi	aer City o	r Town, State, Zip	Code
Maind 2 sith and 27 is reaur		Michelle Favor		or	1				Baltimor			(2006)
re, s 1 ar f Hea litam other		20a. Method of Disposition	2.00	20b. F	Place of Dispo	sition (Name	e of		Date		cation - City or To	wn, State
altimore, mil. Pages 1 ar partment of Heapportant: If Itam y injury or othe		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🌠 Other (S	3 □Removal from 3 Specify)in sta	DIATE	omotory, oron	matery or on	701 p.200	-7 				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-1 ahow any injury or other traumatic event, the Marked Examinat must be notified at once.		21. Signature of Funeral Service	Licensee , A	region	St Ba	Name and ate Ai 11timo	Addres nato	s of Facility my Boar MD 212	d 655 W.	Ba1	timore S	treet
2		23a. Part I Enter the disease, o shock, o heart failure. Lis	r complications that comply one cause on e	aused the deat						arrest,	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	C	arry	nom	72 1	41	Um	11/11	hu	11/13	On, et and
/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):	<i>y</i>	1	4119	00111			2/1/0
	۰	Sequentially list conditions,	b	or as a consec	uenco of):							
bei isi	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consec	derice or):							
), execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):							
9/2 8760 cate be e	cal		La									
9/2// ox 68760, certificate be executed rding physician and use as the burial-transit	Medi	IF FEMALE:	33.2							1		
BOX death cert eath cert in attending of for use	an/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	Ideath 3	Ectopic pre				2	3d. Date of delive Month	Day Year
P.O. Box 68760, that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of cown	leath 5	Other (spe	cify)					
ords, P.O.	P.	Part II. Other significant conditi	ons contributing to de	ath but not res	ulting in the u	nderlying ca	use give	n in Part I.	23e. Did	tobacco u	se contribute to th	ne cause of death?
Cords, P	d by								1 🗆	Yes 2	No 3□ Prob	ably 4 Unknown
ecol	piete								24a. Wa	s an	240. Were auto	psy findings available mpletion of cause of
Vital Rec.	Completed	/							peri	opsy formed?	death?	
f Vital	Be	25. Was case referred to medica examiner?						26. Place of De	eath (Check only			110.0
this this	၉	1 ☐ Yes 2 DNo			ER/Outpatier			4 1140131119	Home 5 Res		ther (Specif	HUSIICE
On Ging	ion	27. Mann of Death 1 Natural 5 Pendi	ng (Mont	of Injury h, Day Year)	28b. Time o Injury	т 28 М	Ic. Injury Work	at ? /es 2 □ No	28d. Describe	now injury	occurred /	
DIVISION For Attending after death. Director: After in by the fune	fical	3 Suicide 6 Could	not be 28e. Place	of Injury - At h	ome, farm, str				28f. Location	(Street and	d Number or Rura	I Route Number,
Div.	Certification;	4 Homicide	buildir	ng, etc. <i>(Speci</i> i	(y)	,			City or To	wn, State))	
Hospi 4 hou Funer Funer	edical	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the Examiner: On the ba and mann	asis of examina	owledge, deat ation and/or in	h occurred a vestigation, i	t the tim in my op	e, date and place pinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner as si place, and due to	tated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certific				29c.	License	number		29d. Date	e signed (Month,	Day, Year)
		Value 1	Malin	01		1	0/1	10/2		g.	1221	15
_		30. Name and address of persor	who empleted caus	e of death (Iter	п 23а) (Туре,	Print)	1	1202.60	RI M	1/2	16.1	olola
		HUNN WI	Toyne.	MI	49/1	MARIE	14	VOUS I	141 20	110,	111/12	12/5
Stat Registra	20	31. Date filed (Month, Day, Year SEP 2	2005	egistrar's Signi	ature	and a		,		/		

State of Maryland / Department of Health and Mental Hygier 0 0 5 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** MARES SEPTEMBER 28 2009 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. NORTHWEST BALTIMENE CONTER 7. Age (In yrs. last birthday)
73 Yrs 8. Date of Birth A. Month, Day, 1932 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 1 F MaryPand 219-28-8786 Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location 77 is marked other than "natural", or Itams 23a or 28a-f show traumatic svant, the Medical Examiner must be notified at 1 Tyes 2 No Director Baltimore Maryland Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1520 Nicodemus Rd. 21136 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married ☐ Yes 2 📉 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 is marked othar than "ns Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Harmon Annie Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an itam 27 is Charles Green - husband P.O. Box 74, Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ita any injury or otl 1 \(\mathbb{R}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other} \((Specify) \) Deer Park Church Cem. Oct. 1,2005 Reisterstown, Md. 22. Name and Address of Facility

Eckhardt Funeral Chapel P.A.

11605 Reisterstown Rd. Owings Mills, Md. 21117 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alute my O CHROLAC Prysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of). Examiner be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached the Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Alanknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an autopsy performed? RESPIRATURY hetli Tus 1 Yes 2 No Division of Vital I or Attanding Physician: after death. Diractor: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P atient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19502 Septempen 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL Kenthwest CONTER B. CONDNAN MID CRLANDO 21/33 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 9 2005 Registrar

			1 10430	State of N	/larylary	d / Dena	rtment of H	lealth and	l Mental H	vaien	е	
		1	For State	State of N	narytari		tificate of		i mornar i	Reg. N	711115	31618
		15	Registrar 1. Decedent's Name (First, Middle, L.	ast)	,	. 3			2. Date of I	Death		3. Time of Death
1 3	Physicia		Jame	25 V	c	Hay	dison		Month 09	2	7 05	8:45 P M
	/Medic Examin		4a. Facility Name (If not institution, ga			1	4b. City, Town, or	r Location of De	ath	40	c. County of Deatl	
			tuturecar			wood		FERSTOWN		NI ab	Balt	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. / 11x M 2 ☐ F	Age (in yrs. i 90	ast birthday) _ Yrs.	If Under 1 Year Months Days	Hours Mi		Day, Year) 9. 8im Co	hplace (State or Foreign untry) NC
	Director	-	212-18-3923 Usual Residence of Decedent		90				Delr.		. 7	
	yland	. [10a. State 10b. County		10c. City	RNER S	cation PATTON					10d. Inside City Limits 1X☐ Yes 2 ☐ No
	Ba-f s	ctor	MD BALTIM	ORE	10	KNEK D.				1		
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23e or 28e-f show if Itam 27 is marked other than "natural", or Items 12e nailled a or other traumatic avent, it is Maraical Examinar must be nailled at	Funeral Director	10e. Street and Number 319 PINE S	TREET			10f. Zip Code	222		10g. C	itizen of What Co USA	untry?
	eath v	erai		12. Was Deceder	nt Ever in U.	S. 13. V	Vas Decedent of H	lispanic Origin?	(Specify Yes or I	No-	14. Race - Ame	ncan Indian,
10	fler de	Fun	 Marital Status Never Married 2 Married 	Armed Force	s?		Vas Decedent of H Yes, specify Cuba		erto Rican, etc.)		Black, White	
036	al', or	Ď	3 X Widowed 4 ☐ Divorced	If Yes, Give 2 Year or Dates	S:	1	☐ Yes 21 No	Specify:			Specify:	BLACK
21215-0036	72 ho natur	Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give I	ent's Usual Occup	during most of v	vorking	16b. I	Kind of Business/	Industry
121	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4c	or 5+)		OO NOT use retired R ATTEND.			BAL'	ro. co.	PUBLIC SCH.
2	filed v Hygie other t		17. Father's Name (First, Middle, Las	st)				18. Mother's N	lame (First, Midd	lle, Maide	n Sumame)	
an	ould be Mental arked o	To Be	RALEITH HA	RDISON				A	DA DAVIS			
Maryland	2 should and Men le marke raumatic	-	19a. Informant's Name/Relationship	(Type, Print)			g Address (Street					
	1 and 2 Health a tam 27 lo		RUTH LEWIS/DAUGH	TER		1	STONEYBR					
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta	20b. P	lace of Disposem <i>etery, crem</i>	sition (Name of natory or other plac		Date		Location - City or	
Baltimore,	t. Partmer rtant njury		4 ☐ Donation 5 ☐ Other (Spec	cify)		LTIMOR	E CEM. Name and Addre			1	IMORE, M	
Bal	permit. Pa Depertmer Important any Injury once.		21. Signature of Funeral Service Lic	ansee Whot	100		01 LAURE					15 F.II., INC
			23a. Part. Enter the disease, or co	mplications that caus	sed the death							Approximate Interval Between
	Physician		shock, or heart failure. List on Immediate Cause (Final	y one cause on each	n line.		ROTIL	13 - 2	LPBRO !		CULAR	Onset and Death
16.	/Medical		disease or condition resulting in death)	Due to (or	as a conseq		70710				,.	DAGA
	Examiner		Sequentially list conditions.	b								
V	D II	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseq	uence of):						
V	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or	as a conseq	uence of):						
760,	eath certificate be exattending physician for use as the burian	cai E		d								
687	certificate nding phys use as the			d								
Вох	h cert endin	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			Ectopic pregnance	у			23d. Date of del	ivery Day Year
	g o G	Physician/Med	in the past 12 months?	4☐Pregnant	t at time of d		Other (specify)			-	MOHIII	Day Todi
P.O.	ac =		9 Unknown Part II. Other significent conditions	contributing to deat	h but not res	ulting in the ur	nderlying cause on	ven in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
	8 5 9	Completed by	PARKINSOI	4	TOUT HOL TOO	uning in the di	ioony ing oddoo gir				2 □ No 3 □ Pr	1
Š	w requir been si should	letec	HUDERTENS	un					24a. W	as an	24b. Were at	utopsy findings available
Rec	E 50 01	duic	T) (POLICE	-014					– au	topsy rformed?	death?	completion of cause of
Vital Records,	. 42 O	0	25. Was case referred to medical					26. Place of I	1 ☐ Yes Death (Check on		0 10 105	202110
	Physician: this certific ral director,	ToB	examiner? 1 Yes 2 No	Hospital:	atient 2 🗆	ER/Outpatien	t 3 DOA	ner: 4 Nursin	gHome 5□Re	esidence	6 □Other (Spe	cify)
0	ding Phys	nc:	27. Manner of Death	28a. Date of I (Month,	njury Da <i>y Year)</i>	28b. Time of Injury	Wo		28d. Describ	e how in	ury occurred	
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigat	the -				Yes 2 □ No	29f Longtion	2 /Ctrant	and Number or P	ural Route Number,
Division of	or Atl	Certification:	4 Homicide determine	289. Flace of	Injury - At hi , etc. <i>(Specif</i>	y) y)	eet, factory, office			Town, Sta		arai noute Nullber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ce	29a. Certifier 4 Certifying	Physician: To the be	est of my kno	wledge, death	occurred at the ti	me, date and pla	ace, and due to t	he cause(s) and manner as	s stated.
	a Hos 24 h a Fur letely	Medical	(Check only 2 Medical Ex	taminer: On the basi and manner	s of examina	ition and/or inv	vestigation, in my	opinion, death of	ccurred at the tim	ie, date ai	nd place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		Λ Λ		29c. Licens	se number		29d. D	ate signed (Mont	h, Day, Year)
			Jasuel	- Lo	elle	ani	19	85-95		4	1/28/0	
	2		30. Name and address of person wi	no completed cause	of death (Iter	n 23a) (Type,	Print) PRK H	21/22	- Ave	BAC	10 MM	7006
	J		31. Date filed (Month, Day, Year)	1+KI+ANI	istrar's Signa	ature -	THE T	यपण.	51,00	211		ST NOO
	St: Regist	ate rar		nns Repa	Jan Joseph	l los	all !					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 19b per Th 8847 9-29-05 vt
State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 27, 2005 SEPTEMBER 10:40PM Irving Hawkins Jr. 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical (4c. County of Death 4b. City, Town, or Location of Death Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Yrs. 510-22-2953 03/25/1928 Kansas Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Towanda Avenue Unit 421 21216 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dentistry 5+ Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Hawkins Sr. Ruth Ann Posey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2035 N. Bentalou St. 19a. Informant's Name/Relationship (Type, Print) Shelley L. Hawkins / Daughter 3000 Towanda Ave. Unit 421. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/29/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Juliature of Funeral Socice Li 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE DAYS disease or condition resulting in death) Due to (or as a consequence of) ACUTE ENDOCARDITIS DAYS Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner Examine

attending physicien and for use as the burial-transit

ed by the a detached t

ate has been signed to page 2 should be det

certificate

: After this certifical tuneral director.

filled in by

within 24 hours atter death. To the Funeral Director; A

Physiclan/Medical

À

Completed

Be

0

Certification:

Medical

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital Hospital or Attending Physician:

permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event page.

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f ehow

ŏ

itams 23a

e tiled within 72 hours atter al Hygiene. I other than "natural", or ital

Baltimore, Maryland 21215-0036

Director

Funera

þ

Completed

Be

ဂ္

traumatic event, the Madical Examinar must be notified at

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

24a. Was an autopsy 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

performed? Yes 2 No 26. Place of Death (Check only one.

2X No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA 28c. Injury at Work? М 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one)

29a. Certifier

3 Suicide

4 - Homicide

29c. License number

D 17695

29d. Date signed (Month, Day, Year)

lou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M. D., 7601 OSLER DRIVE TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year)

State Registrar

SEP 2 9 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** RUS Ham /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death **Examiner** 1619 POPLAR STREET GROVE BALTIMORE NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🛛 F Months Hours Yrs. 220 · 22 · 6650
Usual Residence of Decedent Director 76 01-31-1929 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits item 27 is markad other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be ricified at 1 KYes 2 □ No Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 1619 POPLAR GROVE 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 KM Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE ASSISTANT HEALTH CARE 71H GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANDREW CARIER ARETHA PUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is. any injury or other traur. CLARENCE HAMUN (HUSBAND) IGUA POPLAR GROVE ST., BALTO. MD
Place of Disposition (Name of Date 20c. Locati 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09.30.05 * 4 ☐ Donation 5 ☐ Other (Specify) NATU LAUREL MO 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Fuperal Service Licensia aughn 5151 BADO. NATU PIKE, BADO. MD 23a. Part1. Enlar e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oscleration disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy Month Dav 4☐ Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed No 1 Yes Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ ₩6 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltime MD 2/201

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

GUGW

821

32. Registrar's Signature

			For State		partment of Health and Mertificate of Death		711115	31621
	Physici	an	Registrer 1. Decedent's Name (First, Middle, Last,	11	Crimeate of Death	Reg. N 2. Date of Death Month	lay Year	3. Time of Death
	/Media	al	JAMES H. 4a. Facility Name (If not institution, give	HOWARD	4b. City, Town, or Location of Death	UI de	2 2005 4c. County of Death	7:07 AM
	Examir	er	11 1 1 1 1	IORIAL	BATIMO	re		
	Funeral Director		5. Social Security Number 6. Sec. 240-44-0347 19 Usual Residence of Decedent	7. Age (In yrs. last binthda 12 Yrs	Months Dave Hours Min	8. Date of Birth (Month, Day, Yea 10 - 2 9-1	9. Birthp	olace (State or Foreign ntry) AROUNA
	with the Maryland e or 28a-f show	_	10a. State 10b. County	10c. City, Town or			1	Od. Inside City Limits
	the Maryla 28a-f shov	Director	10e. Street and Number	DAC	TIMORE 101. Zip Code	10g. C	Citizen of What Cour	1 es 2 □ No
	death with	rai Di	3854 ELMORI	A AVENUE	21213	1	1.S.A.	, .
36	s after de or Items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 1 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XI/Yes 2 No If Yes, Give Year or Dates: 1953	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
215-0036	72 hours "netural",		15. Decedent's Edu (Specify only highest grad	cation 16a. De completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work	na 16b.	Kind of Business/Ind	
2	C 98	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	MECHANIC	2	ITY Gove	ernment
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than other treumatic event, the M	To Be	17. Father's Name (First, Middle, Last) JAMES ANDREW	HOWARD	ANNIE	Brown	•	
Ma	alth and 2 sl		SHELIA HOWARDM	CFADDEN 3417	ailing Address (Street and Number or Rura Widgeon Deive. W sposition (Name of sposition (name of sposition (name of sposition (name of sposition))	I Route Number, City	or Town, State, Zip	Code)
ore,	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition 1 Script 2 □ Cremation 3 □ R	emoval from State	sposition (Name of rematory or other place)	Date 20c.	Location - City or To	wn, State
Baltimore	permit. Pages Department of Important: If I eny injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		ON VA CEMETERY 9/2. 22. Name and Address of Facility VAL	8/07 CMI	NGS MILLS	MD SOLE
Ba	Depa Impo Impo eny is		1/3 C/y-		4905 YORK ROAD	· BALTO, A	1D.21212	16141C 3000
	Pnysician		Immediate Cause (Final disease or condition	cations that caused the death. Do not de cause on each line.	enter the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	lan parti			
	D it	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	ory offerty			
الم	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a consequence of):				
8760,	cate be ex obysician the burial	dicail						
Box 68	certification of the second of	lan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy		23d. Date of delive	ery Day Year
o.	that the death ned by the atter detached for u	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			,
Records, P.	w requires that been signed I should be det	Completed by Physician/Me	Part II. Other significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	
Seco	has be	npiet				24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
Vital F	i lcian : The lav certificate has rector, page 2	a	25. Was case referred to medical		26. Place of Death	performed?	death?	2 □ No
of Vi	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ient 3 DOA Other: 4 Nursing Hor	ne 5 Residence	6 □Other (Specify	')
on o	Attending Product of death. Sctor: After to the funerations of the funerations.	tion:	27. Manner of Feath 1 Natural 5 □ Pending □ Accident investigation	28a. Date of Injury (28b. Time (Month, Day Year) Injury		28d. Describe how inju	ry occurred	
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, Stat	nd Number or Rural te)	Route Number,
_	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier 1 Certifying Physical Check only one) 1 Medicel Exemination	icien: To the best of my knowledge, de ler: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(sed at the time, date an	s) and manner as stand of place, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of Certifier	11	29c. License number	29d. Da	ate signed (Month, E	Day, Year)
•	1,	-	> and	Long Wh	1/ >9946	9	177/0	5
	10		30. Name and address of person who co	mpleted cause of death (Item 23a) (Typ	e, Print) / 00 Wymin /	ark b.	iltimo	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 200	32. Pagistrar's Signature	parte			

Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMD, G848, 10/6/05 TI

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Reg. NG 005 Certificate of Death 1. Decedent's Name (First, Middle, Last)

Gertraude R. Hoffmann

Certrude R. Hoffmann 2. Date of Death Month Day Year September 28, 2005 **Physician** 12:25 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Catonsville Renaissance Gardens If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9/20/1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 78 Yrs Director Germany 398-34-3465 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show rthan "natural", or Itams 23a or 28e-f shov the Medical Evantinat must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 United States 711 Maiden Choice Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If Itam 27 is marked other than "na eny injury or other traumatic event. It a Media once. College (1-4or 5+) Elementary/Secondary (0-12) 12 Ouality Control Inspector Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph Riemer Hedwig Karvelitis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6364 Tinted HI, Columbia, Maryland 21045-4533 Jutta Ricketts - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 9/29/2005 | Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas , ir complications that caused the death, shock, or heart failure. List only or cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final mentes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð sema 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? page 2 2 No 1 Yes or Attanding Physicien: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Diractor: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0020040 281 Markey Chouse Cano, Caloanne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vary 31. Date filed (Month, Day, Year) 32. Registrar's Signature 228 State Registrar 9 2005 15000

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eugene Henry Sr. September aa doos 0839 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST.AGnes Hospital N/A 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Months Days 217 32 9995 68 Director 10, Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No N/A Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3028 Lorena Avenue U.S. 21230 Iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Owner Operator Used Car Sales 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny lipiny or other traumatic event ARR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Booth Henry Clara Emma Snyder ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3028 Lorena Avenue Baltimore, Maryland 21230 Genevieve M. Henry / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/24/2005 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 23a Part1. Enter the disease, or experications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Light only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION UNKNOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ertificate has autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 PH/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 2 After this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS PITTLE BATIMORE MIS CURTS MURCES 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Joseph J SEP 2 9 2005 Registrar

Gary Hill	
05-05587	
NTIM	

Hi				ype or Print in				•		_egible.		
)558	5 <i>i</i>		1 - State Unpend Item 2	State of Marylai 3a&27 per me	G847 G847	rtificate of	ealth and Beath	Mental Hy	giene Reg. No.	005	316	24
	Physici		1. Decedent's Name (First, Middle, Las Gary Hill	")				2. Date of De Month August	ath Day 18	2005	3. Time of 1343	Death M
3	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	9		County of De		
	LAdiiii	101	University Hospital			Baltimo	re					
	Funeral Director		5. Social Security Number 6. Se unk	x	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, Year) 196	9. B	irthplace (State o Country)	or Foreign unk
	D >		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	nestian					10d. Inside Cit	the Line in
	sho	5									1k Yes	*
	the N	ect	MD 10e. Street and Number	ва.	ltimore	10f. Zip Code			10a Citia	en of What C	Country?	
	with pe	٥	3 N. Central Aver	110		21202			rog. Oniz	on or vinate	,	n1-
	heath	Funeral Director	44.14.75.180.15		U.S. 13.	Was Decedent of F		Specify Yes or No	- 1	4. Race - Am	ui nencan Indian,	nk
	fer d	E	1 Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 → No		If Yes, specify Cub.	an, Mexican, Pue	irto Rican, etc.)		Black, Wh		
ğ	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: b	lack	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-f show the Madical Exemiter must be notilied at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	ation during most of w	orkina	16b. Kin	d of Busines	s/Industry	
7	ithin	gu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)					
7	led w lygier her ti	ပြ	unk	unk			10 Matheda N	unk	14-1	2		unk
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Miscipal Examinar must be notified at	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mothers Na	ame (First, Middle,	Maiden 3	sumame)		unk
<u>a</u>	2 sh and le m		19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street						
<u>~</u>	and lealth m 27 her tr		O.C.M.E.	006	_	Penn St	reet Bal	_				
ore	ges 1 t of H if Ite or ot		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Loc	ation - City o	r Town, State	
┋	tant:		4 □Donation 5 K Other (Specify									
Baltimore,	permit. Pages 1 and Department of Heatinportant: if Item 2 any Injury or other 2008.		21. Signuture of Funeral Service Licens Ronald S	lade Mrecto		2. Name and Addre State Ana Saltimore	ss of Facility tomy Boa MD 212	rd 655 W	. Bal	timore	e Street	
	Dhysician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the dea one cause on each line. Pneumonia	ath. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory ai	rrest,		Approximate Interval Bety Onset and D	ween
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	guence of):							
	Examiner			,								
		Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):							-
	te be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events	c.								
o,	e exe ien a urial-t		resulting in death) Last	Due to (or as a conse	quence of):							
3760,	ate br hysic he bi	Ical		d								-
. Box 68	res that the death certificati igned by the ettending phy be detached for use as the	by Physician/Medic	IF FEMALE:									
â	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1☐Live birth 2☐Fel	tal death 3	□Ectopic pregnanc	,		2.	3d. Date of de Month		/ear
o O	the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5	Other (specify) _					,	
0.0	hat the	4	Part II. Other significant conditions of	entributing to death but not re	sulting in the u	ınderiving cause on	en in Part I.	23e. Did to	obacco us	e contribute	to the cause of d	eath?
ds,	sign sign d be			•	•	,		101			robably 4 🗇	
Ö	w requir been si should	ete						24a. Was		Odb Wass s	autopsy findings a	ave debte
Ř	has ge 2	Completed						autop		prior to death?	completion of ca	ause of
ē	n: T) ficete or. pa	င်	25. Was case referred to medicat						2 □ No	1 🗷 Ye	s 2 No	
5	eicia s certi irecto	100	evaminer?	Hospital: 1 ☐ Inpatient 2 €	ZER/Outpatie	nt 3□ DOA Oth	or	eath (Check only o		□0*ba+ (0*		
o	Phy arthis arat d	- To	27. Manner of Death	28a. Date of Injury	28b. Time o			Home 5 Resid			өспу)	
<u>o</u>	th. : Afte	흝	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2∐No					
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or F	Rural Route Numi	ber,
	24 hours a Funeral letely filled	Medicai C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kr inar: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the time time the time t	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and	and manner a place, and du	as stated. se to the cause(s))
	To the within 2 To the complet	Me	29b. Signature and title of certifier	210172		29c. Licens	e number		29d. Date	signed (Mor	nth, Dey, Year)	
)	- > + ō		> you share	Jeec On n		α	ME		A1121	st, 19,	2005	
•			30. Name and address of person who d	ompleted cause of death (Ite	em 23a) (Tvne					,,		
			Tasha Z Green				nn Street	Baltimore	Man	and 21	201	
	Sta	ate	31. Date filed (Month, Day, Year)	22. Registrar's Sign					,)			
	Regist	rar	SEP 2 9 200	15	M A.	nell 1						

DHMH 17 Rev 1/2001

OFIGINAL

			For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of Heartificate of De			2005	5 31625
			1. Decedent's Name (First, Middle, L	ast)	-			2. Date of Death Month		3. Time of Death
	Physici /Medio		Catherine H	leiger			5	September	Day Ye	1.4
	Examir		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Loc	cation of Death	-	4c. County of D	
			Keswick Nur			Ba1	timore			
	Funeral Director			. Sex 7. A 1 ☐ M 2 🛱 F	ge (In yrs. last birthday) 88 Yrs.		lours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign Country)
			215-03-6550 Usual Residence of Decedent		00			Dec 1, 1	916 M	aryland
	nylan thow	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	89-f 8	Director	MD		Bal	timore				1√ Yes 2 No
	with the		10e. Street and Number			10f. Zip Code		100	j. Citizen of What	Country?
	eath	eral	700 W. 40th St	12. Was Decedent	Ever in U.S. 13	Was Decedent of Hispa		eify Ves or No.	14 Bace - A	SA merican Indian,
(0	riter d	Funeral	1 Never Married 2 Married	Armed Forces	No	TYes, specify Cuban, N	Mexican, Puerto H	lican, etc.)	Black, W	/hite, etc.
ĕ	ours a	d by	3 ₩ Widowed 4 Divorced	If Yes, Give 22 Year or Dates:		1∐Yes 2tx No S	Specify:		Specify:	white
2	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28e-f ahow Ita Modeal Excentina is use the multified at	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occupation kind of work done during		g 16	b. Kind of Busine	ess/Industry
12	withir ene. than	duc	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired)		11		- D t t-
2	Hygie other ent,	a)	unk 17. Father's Name (First, Middle, Las	unk st)	wal	tress 18.	. Mother's Name			s Restaurant
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. itam 27 is marked other than "netural", or Itams 23a or 28e-f ahow other traumatic avent, I're M. Jicel Ex., iliter institutional	To B	Herman Mattes	Sr			Catheri	ne Minni	e Nolte	
ary	2 should and Men is marke aumatic	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and	Number or Rural	Route Number, C	City or Town, Stat	e, Zip Code)
	and sealth m 27 m 27 ther tru		Joanne Rigby/da	ughter		Weyburn Roa			21237	
altimore,	ges 1 t of H if ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cres	sition (Name of natory or other place)	Da	ite 20	c. Location - City	or Town, State
≣	t. Partmen		'4 ☑Donation 5 ☐ Other (Spec		1		1			
Ba	permit. Pages 1 and Department of Healt Important: if itam 2 any injury or other once.		21. Si natur of Funeral Service Lic	Wade Nip	St	. Name and Address of ate Anatom	y Board	655 W. B	altimore	e Street
			23a. Part1. Enter the disease or co	mplications that cause	d the death. Do not en	.ltimore, M er the mode of dying, s		respiratory arrest		Approximate
	Pnysician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	ine.	+ `.,				Interval Between Onset and Death
	/Medical		disease or conditional resulting in death)	aDue to (or at	consequence of):	O (C /4				years
6	Examiner	L	Sequentially list conditions,	b						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury	Due to (or as	s a consequence of):					
	execut and al-trar	xan	that initiated events resulting in death) Last	cDue to (or as	s a consequence of);					
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d						
9	ntificat ng phy as th	Medi	IF FEMALE:							
Вох	that the death certificed by the attending properties as	by Physiclan/Me	23b. Was decedent pregnant		2 Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
o.	the all	ysic	1 Yes 2 No	4∏Pregnant a 9☐ Unknown	at time of death 5	Other (specify)			WORL	Day Feat
Ω.	that the ed by detac	Ph.	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause given in	n Part I.	23e. Did tobac	cco use contribute	e to the cause of death?
ds,	uires tha signed		Meuren	t mer	imorias	osteop	ovosis	1 ☐ Yes	2 No 3	Probably 4 Unknown
Records,	w requir s been si should	olete						24a. Was an	24b. Were	autopsy findings available to completion of cause of
	The tav te has vage 2	Completed						autopsy performe	d? deatr	to completion of cause of i? 'es 2 \sum No
Vital		BeC	25. Was case referred to medical examiner?			26	. Place of Death		(10)	35 21110
	Physic this ce al dire	o L	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati			4 Volursing Hom	e 5 🗆 Residend	e 6 □Other (S	pecify)
Division of	ling P	ion:	27. Manner of Peath 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o ay Year) Injury	Work?		3d. Describe how	injury occurred	
Sic	Mtendi death. ctor: A y the fu	icat		be 29a Blace of In	jury - At home, farm, str		2 No	of Location (Street	at and Number or	Rural Route Number,
<u> </u>	after Dirac	Certification:	4 ☐ Homicide determine	building, e	tc. (Specify)	eet, lactory, onice		City or Town, S		ridiai riodia ivamber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director.		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge, death	occurred at the time, of	date and place, ar	nd due to the caus	se(s) and manner	as stated.
	tha Ho in 24 in Fu pletel	edical	(Check only 2 Medical Exa	aminer: On the basis of and manner si	of examination and/or in tated.	estigation, in my opinio	on, death occurred	d at the time, date	and place, and o	fue to the cause(s)
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier	10		29c. License nu	imber	29d	. Date signed (Mo	
			10/1 HAThe	- 1hly	up	1/25	407	De	Aente	123,2005
			30. Name and address of person who	o completed cause of	death (Item 23a) (Type,	Print) Purles (1. Pals	a mil	21209	
	Sta	te	31. Date filed (Month, Day, Year)	8/	rar's Signature	<u> </u>	10000	0 . 7. 0. 0		
	Registr		SEP 2 9 2	2005	as the fight	all a				

			1 - For State Registrar	State of Maryla		artmen rtificat			d Mental H	ygiene	005	0.1	
	Physic /Medi		Decedent's Name (First, Middle, Last Joseph E. Hollar						2. Date of D Month	eath Day	Year	3. Filme bi	n M
	Exami	ner	4a. Facility Name (If not institution, give 2822 Roselawn Avenue 5. Social Security Number 6. Se		s. last birthday)	4b. City,	Balt	ocation of Dimore	Death	n/a			
	Funeral Director		215-09-1788 Usual Residence of Decedent	QM 2□F 91	Yrs.	Months	Days		Hrs. 8. Date of 8 (Month, 10)	1914	Coun	lace (State of ltry) MOPE,	-
	the Maryia 28a-f shov	ector	MD 10b. County N/A		altimor		0-1-						ity Limits
36	after deeth with or items 23a or aminer must be	y Funerai Director	2822 Roselawn Aver 11. Marital Status 1 Never Married 2 Married	1UC 12. Was Decedent Ever in Armed Forces? 1		21	L214 dent of His ofly Cuban	panic Origin' , Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	0- 14. R	S.A. ace - Americ lack, White,	an Indian, etc.	
21215-0036	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id Hygiene. Id other than "natural", or Items 23s or 28s-f show avant, the Modical Exerting must be notified at	Completed by	3 X Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8 Years	Year or Dates:	16a. Dece (Give life.	dent's Usua	al Occupat rk done du se retired)	ion iring most of	working	16b. Kind of	Business/inc		
Maryland	ed la b	To Be C	17. Father's Name (First, Middle, Last) Charles Austin H					Bes	Name (First, Middle sie Butle	er			
	12 E E		19a. Informant's Name/Relationship (Ty Carol Hollar - Dau 20a. Method of Disposition	ghter		2 Ros	elaw	n Aven	r Rural Route Numb ue Balti Date	imore, M	MD 21	214	
Baltimore,	permit. Pages 1 are Department of Hee Important: If item any injury or othe once.		1 Gurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature Property	emoval from State	cemetery, crer eadowri	natory or ot dae C	ther place, Ceme to	erv 10	/01/2005 Baltimore,		je, MD	wn, State	
	Physician /Medical Examiner	e.	23a. Part1. Enter — disease , or complishock, or he in failure. Li it only or immediate Cau e (Final disease or con titrin resulting in death). Sequentially list conditions,	0 +	ath. Do not ent	er the mode	e of dying,	such as care	5305 Hamfo diac or respiratory a	arrest,		Approximate Interval Bett Onset and I	ween
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to time data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse									
O. Box 6	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pre					ate of deliver	,	/ear
ords, P.	equires that sen signed tould be de	b	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying ca	iuse given	in Part I.		tobacco use cor Yes 2 □ No			
Division of Vital Records,	The law ate has b page 2 sl	Completed	OF MI						24a. Was auto perfo 1 Yes	psy ormed?	. Were autop prior to com death? 1 Yes 2	sy findings a pletion of ca 2□ No	available ruse of
₹	Physician: this certific ral director,) Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	75000		Other		Death Check only				
on of	ing After une	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		3c. Injury a Work?	4 CHARLESIN	g Home 5 Resi 28d. Describe	dence 6 Ot how injury occu			
Divisi	or A lifter Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, stre				28f. Location (City or To	Street and Num wn, State)	nber or Rural	Route Numb	ber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (one)	ician: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death ation and/or inv	estigation,	in my opir	ion, death o	ace, and due to the courred at the time,	date and place	, and due to	the cause(s)	
	To To	<		Konslender 1	N)		License r	1x 7)		29d. Date signe 9-2	8-05		
	V		30. Name and address of person who co		m 23a) (Type, F	Print)	rel,	SALTO	MD ZAZ	-76			
e _{ss}	Sta Registr	_	31. Date filed (Month, Day, Year) SFP 2 9 200	32 Registrar's Sign	ature 600	Med							

			ype or Print				_	•	. .
		For State Registrer	State of Man	•	tificate of i		-	Reg. N2 0 0 5	31627
Physici	 200	Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
/Medic	al	Francis James Holt 4a. Facility Name (If not institution, give si			4h City Town o	r Location of Death	09-	27 - 05 4c. County of D	3.30 PM
Examir	er	Franklin Square	HUS ON HELL (enter	Roseda H	Location of Death		0 1	more
Funeral Director		5. Social Security Number 6. Sex	7. Age (III	94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month Da 8/5/19	th 9.	Birthplace (State or Foreign Country) aryland
Maryland	tor	10a. State MD 10b. County Baltimore		oc. City, Town or Low White Mar					10d. Inside City Limits 1 ☐ Yes 2 No
h with the 23a or 28a	Funeral Director	10e. Street and Number 11415 Philadelphia	Road		10f. Zip Code 21162			10g. Citizen of What	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Evantment must be rediffed at 2008.	by Funer	11. Marital Status	2. Was Decedent Eve Armed Forces? 1 \textbf{\textit{Q}}Yes 2 \subseteq No If Yes, Give Year or Dates: \textbf{W}	!	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		merican Indian, /hite, etc. hite
vithin 72 hounder ne "natura hen "natura e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occup kind of work done o OO NOT use retired	durina most of wor	king	16b. Kind of Busine	ess/Industry
filed v Hygie other t	Be Co	12th 17. Father's Name (First, Middle, Last)	5+	Inves	tigator	18. Mother's Nam	ne (First, Middle	Security , Maiden Sumame)	
Menta Menta Brked artic ev	To B	Louis Holtzner				Mary Ba	nnon		
d 2 sho		19a. Informant's Name/Relationship (Type Fran Holtzner/dauc			-			er, City or Town, Stat Marsh MD	e, Zip Code) 21162
s 1 and if Heeli item 2 other		20a. Method of Disposition		20b. Place of Dispos			Date	20c. Location - City	
Page ment o ent: if ury or		1 ☐ Burial 2 🏋 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metro Cre	matory	9/28/	/05	Baltimore	, Maryland
permit. Departi		21. Signature of Funeral Service License	1		Name and Address	CV		edale Fune edale MD	ral Home 21237
Physician /Medical Examiner	xamlner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ations that caused the a cause on each line. Acute Due to (or as a co	onsequence of):	ar the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
yath certificate be ex attending physician for use as the burial	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 Yes 2 1 No	Due to (or as a co	oregnancy	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
thet the de ad by the detached	hysi	9 🗆 Unknown	9□ Unknown		-				
w requires the been signed should be del	pleted by F	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the ur	derlying cause give	en in Part I.	23e. Did t		e to the cause of death? Probably 4
	Comple	L					24a. Was autor perfo 1 \(\text{Yes} \)	osy prior death	autopsy findings available to completion of cause of ??
eicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Unpatient	2 ER/Outpatien	3□ DOA Oth	26. Place of Dea		one) dence 6 🗆 Other (S	**************************************
To the Hospitel or Attending Physicien: within 24 hours efter death. To the Eunarel Director: After this certifica completely filled in by the funeral director.	\vdash	27. Mann Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		28c. Injun Work	y at		how injury occurred	респу
To the Hospitel or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	eet, factory, office		28f. Location (: City or Tox		Rural Route Number,
To the Hospitel or Mithin 24 hours efte To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying Physi (Check only one)	cian: To the best of mer: On the basis of exand manner stated	amination and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
To t With To t	M	29b. Signature and title of certifier			29c. License	052024	4	. , - , ,	5
2		30. Name and address of person who cord of the second of t	r 9000 F	(Item 23a) (Type, I	Print) Square I	Drive Bal	hmore,	Md 212.	37
Sta Registr	1.0	31. Date filed (Month, Day, Year) SEP 2 9 201	32. Haristrar's	Signature	and I				
HMH 17 Rev 1/2	001		1	19					

DHMH 17 Rev 1/2001

			- FUI	epartment of Health and Me Certificate of Death	Reg. No	(11115 3 1 6 7 8 -
	Physici /Medic	an :al	Decedent's Name (First, Middle, Last) HARRY ANTHONY HEROLD		2. Date of Death Month Da SEPT. 25,	2005 9:00 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 331 S. BOULDIN STREET	4b. City, Town, or Location of Death BALTIMORE		c. County of Death N/A
	Funeral Director		5. Social Security Number 220−36−9798 6. Sex 1	day) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth Month, Day, Year, JULY 19,	9. Birthplace (State or Foreign Country) MD.
	aryland show d et		Usuel Residence of Decedent 10a. State 10b. County 11 / A 11 / A	or Location BALTIMORE		10d. Inside City Limits 1 X Yes 2 □ No
	r 28e-f	Funeral Director	MD . N/A	10f. Zip Code	"	itizen of What Country?
	s 23e o	eral D	331 S. BOULDIN STREET 11. Marital Status 12. Was Decedent Ever in U.S.	21224	ONI	TED STATES 14. Race - American Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural', or Itams 23e or 28e-f show entry injury or other traumatic avant, I'm Medical Evartifier must be notified at ances.	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 VNo If Yes, Give A Year or Dates:	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ring Yes 2 K No Specify:	ican, etc.)	Black, White, etc. Specify: WHITE
21215-0036	in 72 ho "natur	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired)	16b. k	Kind of Business/Industry
	ygiene. ygiene. yer thar		UIII	ONSTRUCTION WORKER	(Cine Adidale Adeide	UNION
land	uld be fi Aental H rked otl tic avar	То Ве	17. Father's Name (First, Middle, Last) UNKNOWN	ROSE HER	(First, Middle, Maider RGET	i Sumame,
Maryland	nd 2 sho Ith and h 27 is ma reaums			Mailing Address (Street and Number or Rural of BANK ST., BALTIMOR		
	jes 1 ar of Hea tf itam or other	The Control	20a. Method of Disposition 20b. Place of D cemetery,	isposition (Name of crematory or other place)		ocation - City or Town, State
Baltimore,	nit. Pag bartment ortant: injury (*4 □ Donation 5 □ Other (Specify) MT . CON 21. Signature of Superal Service Licentee	22. Name and Address of Facility CHA	ARLES S. Z	LLS CHURCH, VIRGINIA EILER & SON, INC.
ä	permi Depa Impo eny ir		23a, Part1. Enter the disease of complications that caused the death. Do not	6224 EASTERN AVE., Et enter the mode of dying, such as cardiac or	BALTIMORE,	MARYLAND 21224 Approximate
	rnysician /Medical Examiner		shock, or heart failure list only one cause on each line. Immediate Cause threat disease or condition resulting in death) Due to (or as a consequence of)	e Cardiovascul		Interval Between
8760,	ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)			
P.O. Box 68	ath certific trending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	juires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	1	23e. Did tobacco	use contribute to the cause of death?
il Records,	The ate h	Completed	Hypertension Morbid Obeisity		24a. Was an autopsy performed?/	24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \] 2 \[\text{No} \]
Vital	Phyaician: Th r this certiticate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (attent 3 DOA Other: 4 Nursing Home	(Check anly one) e 5 Residence	6 ☐Other (Specify)
on of	ling Phy	lon: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inju	ne of 28c. Injury at 28	Bd. Describe how inju	iry occurred
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specily)		Bf. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
	Hospits 24 hours Funeral stely tilled	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.			
)	To the within To the comple	Med	29b. Signature and title of certifier	29c. License number 7003384 7	29d. Da	ate signed (Month, Day, Year)
	4			ype, Print) Eastern Ave Beltim.	ice MD	21224
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 9 2005 32. Begistrar's Signature	Goods		
	negisti	aı	SEP 2 9 2005 Blacker &			

DHMH 17 Rev 1/2001

			1- For Amend Item State of Maryland Department of the State of Theorem State of the State of The Sta	erment of Health and M 29/05dhb tificate of Death		
	• Physici	an	Decedent's Name (First, Middle, Last)	~ .	2. Date of Death O	Day Year
	/Medic	al	Steve	Jones	there is	S 945 50 7 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Honkins Hospital	4b. City, Town, or Location of Death Baltimore Ci-	tr.	ic. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
36.	Director		216-42-0645 ¹ X M 2□F 60 Yrs.	Days Hours Will.	Aug 15, 1	
	and w		Usual Residence of Decedent 10a. State unk 10b. County unk 10c. City, Town or Lo	cation		unk 10d. Inside City Limits
	Many I eho	tor	unk			unk¹□Yes 2□No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or items 23s or 28s-f ehow other traumatic event, the Medical Evarinar must be notified at	I Director	10e. Street and Number unk	10f. Zip Code	unk 10g. 0	Citizen of What Country? USA
	death	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spot Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s after	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 €7 No	I ☐ Yes 2 ☑ No Specify:	,	Specify: white
215-0036	ture!	ed b	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	unk 16b.	Kind of Business/Industry unk
215	thin 72 8. 9n "na Media	Completed	(Specify only highest grade completed) (Give life. I	kind of work done during most of work DO NOT use retired)	ing	
21	filed wii Hygien sther th		unk unk	117)z 10 kilotharia kiama	/First Middle Moids	og Cumomo)
and	ould be filed with Mental Hygiene. arked other ther atic event, the M	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide Lene Smith	an Sumame)
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, the Me	으	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	g Address (Street and Number or Rura	al Route Number, City	y or Town, State, Zip Code)
	1 and 2 Health a em 27 le			N. Wolfe Street E		
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State
Balti	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral Service Land Part of	Name and Address of Facility tate Anatomy Boar altimore, MD 212		altimore Street
Z.			23a Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
N.	Pnysician		Immediate Cause (Final disease or condition resulting in death)	intestinal Henor	rrhuge	Onset and Death Y Lours
	/Medical Examiner		Due to (or as a consequence of):	intestinal Hemore	we Conc	3 days
	Alexandra I	er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury based and the cause (Disease or injury based and the cause (Disease or injury based and the cause (Disease or injury based and the cause of the cause (Disease or injury based on the cause of the c	Jornacii Coll) Chica	
	cuted nd ransit	Examiner	triat irritated events			
90,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
8760,	physics the b	dlcal	d			
O. Box 6	The law requires that the death certificate be executed at the seen signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	es that thighed by be detact	y Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
rds	w requires been sign should be	ed by			1 Xes	2 No 3 Probably 4 Unknown
Records,	law requ as been 2 shoult	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
3	eicien: The law s certificate has t lirector, page 2 s	Con			performed?	death? No 1 Yes 2 No
Vital	Physicien: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Othor	h (Check only one)	
of	Physic this aral di	To To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nuising No	me 5 Hesidence 28d. Describe how in	6 ☐Other (Specify) jury occurred
ion	Attending F death. ctor: After y the funera	atlor	1 Xatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No		
Division	or Attency after death I Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl and manner stated.	occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			10 mgue V	1203-000	7 /26	P+12,2007
			30. Name and address of person who completed cause of death (Item 23a) (Type, Miguel Munoz, The Johns Hopici	Print) rs Hospital, 600 i	North Wolfe	ond place, and due to the cause(s) Date signed (Month, Day, Year) PHIZ, ZUU J St, Bultimore MD 21287
蓝水	Sta Registi		31. Date filed (Month, Day, Year) SFP 2 2 2005	parti		

•			For State Registrar	State of Maryla		artment of rtificate of			Reg. No.		316	530
П	Physicia	an	1. Decedent's Name (First, Middle, Li	JACKSON				2. Date of D	Day	Year	3. Time of	Death P M
	/Medic Examin	al	JEROME L. 4a. Facility Name (If not institution, gir			4b. City, Town,	or Location of	09 · 20		County of Death	4:45	
	Examin	ei	108 N. EDGEW		•	BALTIM	ORE			NA		
	Funeral Director		212.58.1048	Sex 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Yea Months Day		Min (Month D	rth ay, Year) 1951	9. Birthp Cour	lace (State o try) MD	r Foreign
	/iand		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside Ci	ty Limits
	e Man	ctor	MD NA	BA	KIIMOR	٤					1 🔀 Yes	2 🗌 No
	vith th	Director	10e. Street and Number	arne er		10f. Zip Code	100		10g. Citi:	zen of What Cour	itry?	
	ns 23e	Funerai	139 N. AISQUITH	STREET 12. Was Decedent Ever in	U.S. 13.	Was Decedent of		gin? (Specify Yes or N	0-	14. Race - Americ	an Indian,	
9	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cu 1 ☐ Yes 2 ☑ No		gin? (Specify Yes or N n, Puerto Rican, etc.)		Black, White,		
003	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show itsal Ezami net must be multified at	d by	3 Widowed 4 Divorced	Year or Dates:	10- D.				100 10	Specify: BLA		
21215-0036	S - 3	piete	15. Decedent's E (Specify only highest gi	ade completed)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e durina mosi	t of working	16D. Kii	nd of Business/In	dustry	
212	M E T	Completed	Elementary/Secondary (0-12) 12 TH GRADE	College (1-4or 5+)	SHEET	METAL	MECHA	NIC	CON	JSTRUCT	ON	
Maryland	ed in b	To Be	17. Father's Name (First, Middle, Las WILLIAM JACKS)				18. Mothe	or's Name (First, Middle OVS CAMPE		Sumame)		
lan	and and ls m	Ì	19a. Informant's Name/Relationship					er or Rural Route Numi				
	1 an Heal em 3		KDSA JACKSON 20a. Method of Disposition	(NIFE)	1319 D. Place of Dispos	N. AISQI		ST., BALTO		2120; cation - City or To		
nor	ages ent of nt: If it y or c		1 M Burial 2 ☐ Cremation 3 (14 ☐ Donation 5 ☐ Other (Spec		cemetery, cre NG PA	matory or other pi OV		9.24.05	RAN	IDALL8TO	AIAI.	MD
Baltimore,	permit. Par Departmen Importent: any injury once.		21. Signature of Funeral Service Lice		V.	2. Name and Add	ress of Facilit	E FUNERAL PIKE BALTO	SERVI	CE	010	,
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	aplications that caused the de							Approximate Interval Bety	ween
	Prysician		Immediate Cause (Final disease or condition	A END STAGE	HERAL	CELLULA	IR CAN	JCER			YR.	Jeath
	/Medical Examiner		resulting in death)	Due to (or as a cons		10501	VADICE	20			YR	
		- F	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ASCHES Due to (or as a cons	ESOPH equence of):	AGEAL	VARICE	<u>ي</u>			16	
14	cuted nd ransit	Examiner	that initiated events	. CIRRHOSIS						1	YRS.	
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a cons		IVE PULIV	ONARY	DISEASE	,		Yes	
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3[□Ectopic pregnan	су		2	3d. Date of delive		/ear
ds, P.	uires that n signed b	by	Part II. Other significant conditions HEPATITIS C	contributing to death but not r ANEMIA	resulting in the t	underlying cause o	iven in Part I.			se contribute to th ¶No 3 ☐ Prob		leath? Jnknown
of Vital Records,	aw requir is been s 2 should	Completed	BACTERIAL PE	RITONMS				24a. Wa:		24b. Were auto	psy findings a	available
I Re		Com						perf	ormed?	death?	2 No	1030 01
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			the ear	of Death (Check only			MOTHERS	SHOME
	Phys r this ral di	To To	1 ☐ Yes 2 K No 27. Manner of Death	28a. Date of Injury (Month, Day Year,	ER/Outpatie	of 28c. In	urv at	rsing Home 5 Res			/)	, wonte
ion	nding Ph ath. r: After th e funeral	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation) Injury		ork? ⊡Yes 2.⊡	No				
Division	al or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not determine		t home, farm, st ecify)	reet, factory, offic	Э	28f. Location City or To	(Street and own, State)	d Number or Rura	l Route Num.	ber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C		hysician: To the best of my laminer: On the basis of exame and manner stated.)
	To th withir To th	Me	29b. Signature and title of sertifier	Ruil	601	29c. Lice	nse number	49		signed (Month,		
•	10		30. Name and address of person who	completed cause of death (I	tery 23a) (Type	, Print)				hh. hu	J-)	
	10		ALLEN REILLY,	MD , 4 E	. ROLL	NG CRO	8SROA1	DS, STE 3	11 , 1	BALTO.N	10 21	228
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2	32. Registrar's Sig	gnature	Goods.						

DHMH 17 Rev 1/2001

			For State Registrar		State o	of Mary	yland / Dep <i>Ce</i>	artment of F					05	31631
	a.	3	Decedent's Nan	ne (First, Midd	le, Last)						2. Date of Dea Month	-		3. Time of Death
	Physici /Medi			HINES	JOHNSC						09.26	- 2005	Year	10:15 AM
	Examir	er	JOSEPH		on, give street and nu IE HOSPI	_		4b. City, Town, of BALT1 MC	-	n of Death		4c. County	of Death	
	Funeral Director		5. Social Security 217. 20.	Number	6. Sex 1 ☐ M 2 🗷 F	7. Age (I	n yrs. last birthday) Yrs.			Min.	8. Date of Birth (Month, Day)	Year)	9. Birthi	place (State or Foreign ntry)
	p		Usual Residence		,		Dc. City, Town or Lo	ocation			0. 0.7	1-120		10d Inside Ch. Linia
	Maryla -f shor	tor	MD	1	۱۵		BALTIMOR							10d. Inside City Limits 1 Yes 2 No
	death with the Maryland ims 23a or 28a-f show	lrec	10e. Street and No					10f. Zip Code			1	0g. Citizen of \	What Cou	ntry?
	ath wil	raiD			MIN AVE			2121				·	ISA	
36	iii = 1	by Funeral Director		rried 2 Mar	If Yes, Gi	orces? 2 X No ve		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	k, White,	
00-	"natural",			15. Deceder	nt's Education	ates:	16a. Dece	dent's Usual Occup	oation			16b. Kind of Br	BLA	
© 10 % Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, it a Madical once.	Completed	Elementary/Sec 121H GR	condary (0-12)	College (kind of work done DO NOT use retired LERK	during mo d)	ost of work		SOCIAL	9E	curity
2√4 B	e filed Il Hygi other	Be Co	17. Father's Name					LUICA	18. Mot	her's Name	e (First, Middle, I			curi y
0/	ould b Menta marked	TOE		POPE						·	HATLEY			
(a) E	d 2 sh th and t7 is m traum		19a. Informant's MICHELLE	_				ng Address (Street MONDAW		_	al Route Number		State, Zip	
الح وا	item 2		20a. Method of Dis	sposition			20b. Place of Dispo		1			20c. Location -		
· タクル/ルン Baltimore	Page ment c ant: if ury or			2 ☐ Cremation 5 ☐ Other (5	3 □Removal from Specify)		WOODLAN			09.30	0.05	BALTO.	MD	
	permit. Depart Import any inj		21. Signature of F	uneral Service	Licensee 1			Name and Address Name and Na					29	
3			23a. Part1. Enter shock, or he	disease, o	r complications that of	aused the							/	Approximate Interval Between
	Physician /Medical		Immediate Cause disease or conditi resulting in death)	ion	_ a	are	MADI	NA OT	1 /M	na	alith	MOT	3	Onset and Death
	Examiner				Due to	(or as a co	onsequence of):		,,,,					/
A	р <u>н</u>	ner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of	onditions, immediate derlying	b	(or as a co	onsequence of):							
5 8	ficate be executed physicien and sthe burial-transit	Examiner	Cause (Disease o that initiated even resulting in death)	its	c. Due to	(or as a co	onsequence of):							
EXP	e be e rsicien e buria	dicat				(
. 0	rtificati ng phy	a a	IF FEMALE:										l	
Z. Box	es that the death certifications that the death certification of the detached for use as	Iclan/M	23b. Was deceded in the past 12 1 Yes 2	2 months?	4☐Pregr	inth 2 [nant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	y			23d. Dat Mo	e of delive	ery Day Year
S 0	at the	by Physi	9 Unknow	'n	9□ Unkn	_					1			
John Records.	w requires the been signed should be d		Partil. Other sign	meant conditi	ons contributing to d	eath but n	ot resulting in the u	nderlying cause giv	en in Part	l. 		es 2 No	3 Prob	he cause of death? pably 4 Danknown
Reco	uicien: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Completed			/						24a. Was a autops perform	ned?	death?	ppsy findings available mpletion of cause of
V Sita		BeC	25. Was case refe examiner?	arred to dica					26. Plac	e of Death	1 ☐ Yes 2 1 (Check only on		100	11
ORI	Phys rthis ral di	- To	1 Yes 2] No	Hospital: 1 28a. Date	Inpatient of Injury	2 ER/Outpatier 28b. Time o		4 L IN	-	me 5 Reside	-	er (Specif	HOSPILL
A	Attending F r death. sctor: After by the funera	ation	1 1 atural 2 Accident	5 🗌 Pendii		th, Day Ye	ea <i>r)</i> Injury	Wor	rk? Yes 2[E00. D030/100 110	w many occur	00	
Division	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	nined 288. Place	of Injury	- At home, farm, str Specify)	eet, factory, office		1	28f. Location (St. City or Town	reet and Numb , State)	er or Rura	I Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directomplately filled in by		29a. Certifier	1 🕜 Certifyi	ng Physicien: To the	best of m	ny knowledge, deat	n occurred at the tir	me, date a	ind place, a	and due to the ca	use(s) and ma	nner as si	tated.
	To the He within 24 To the Fu	Aedical	(Check shift) one)	2 medical	and man	asis of exa ner stated	airiination and/or in	vestigation, in my o	pinion, de	ath occum	ed at the time, da	are and place, a	and due to	o the cause(s)
	with To	Σ	29b. Signature and	u fille of certific	Polar.	1 11	m	29c. Licens	1.7	010	29	9d. Date sign	(Month,	Dy Year)
	\mathcal{O}_{I}		30. Name of add	tress of person	who completed car	e of deat	(llem 2)a) (Type,	Print)	0	11	11/1	1/2	4/0	
10	\		31. Date filed (Mo.	Mil Cay	100 40		Merul	DA MA	P.7	He	11/1/2	120		
	Sta Registi		JI. Date filed (MO.	SEP	2 9 2005	West.	Signature	Sperker						

LAKKI JACKSUN 05-06574 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar 31632 Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 26,2005 **Physician** F. JACKSON 9:31P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Funeral Months 1 № M 2 🗆 F 55 214.56.4263 09.11.1950 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show or than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at NA 1 Yes 2 No Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1214 MCCULLOH STREET 21217 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **Z**No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CAIN TECH. 12 TH GRADE VERIZON NA of Health and Mental Hygie f Item 27 is marked other r other traumatic event, in other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Heart: If Item 27 is marked oft jury or other traumatic even LEON SMITH SHIRLEY GOODMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. JACKSON 1214 MCCULLOH ST. BALTO. (WIFE) MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 10.01.05 GREENMOUNT BALTO, MO 21. Signature of Fundral Securce Lice 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BADD NATU PIKE, BALTO MO 21229 Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Anterosclarenic Chridityascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-translt Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown been signated Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No certificate ha 1 ☐ Yes After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ths 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certif OCME SEPTEMBER 27,2005 of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 who completed cause 30. Name and address of person Y) Titus M.D JACK W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 9 2005 Registrar

		1	= State Amend #5 I	State of M Per Inf. G85	aryland / De 8 8/23/06	partment of Hea	alth and Me eath	ental Hygi	ens 005	31633
Phys	siciar	1	1. Decedent's Name (First, Middle					2. Date of Death Month	Day Year	3. Time of Death
	edica mine		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or Loc	cation of Death	eptembe	4c. County of Dea	5 (U A
Europ	al los		SON SECULIS	6. Sex 7. AS	ge (In yrs. last birthda	y) If Under 1 Year If	Under 24 Hrs.	B. Date of Birth (Month, Day,		A thplace (State or Foreign
Funer Direct		1	250-24-8053 250-40-8053	1 ⊠ M 2□F	82 Yrs.	Months Days H		(Month, Day,	123 C	thplace (State or Foreign ountry)
faryland show	î l		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	Location				10d. Inside City Limits
he Mar 28e-f st				JA	BALTIMO			10	0.00	16X Yes 2 No
3a or 2	2	ב <u>ַ</u>	10e. Street and Number 806 N. APPLET	DAI STREET	-	10f. Zip Code 21217		10	lg. Citizen of What Ci USA	ountry?
er deatl		Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	?	3. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Am-	
ours after		2	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give	No	1 ☐ Yes 2 🗷 No S	pecify:		Specify: BL	ACK
n 72 ho		leted	15. Decedent (Specify only highes	t's Education st grade completed)	16a. De	cedent's Usual Occupation ve kind of work done durin b. DO NOT use retired)	n ng most of working	7 1	6b. Kind of Business	/Industry
be filed within 72 hours after death with the Maryland ital Hygiene. d other than *neturel; or items 23e or 28e-f show event. Ite Modical Exerting the must be not lifted at		Completed	Elementary/Secondary (0-12) 5 IH GRADE	College (1-4or	5+)	RPENIER			CONSTRUC	TION
ite; Mally Italia ZIZIOJOOO s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event. Ite Modical Exemine musitly in Milled	6	10 86	17. Father's Name (First, Middle, I WALLER JACOB	,		_	Mother's Name (_	•	
2 should and Men is marke	F		19a. Informant's Name/Relationsh	hip (Type, Print)	19b. Ma	tiling Address (Street and				Zip Code)
1 and Health em 27		-	ETHEL JACOBS 20a, Method of Disposition	S (WIFE)	20b. Place of Dis	N. APPLETON position (Name of	91., B1	ALTO. M	D. 21217 0c. Location · City or	Town, State
mit. Pages partment of portent: If it it in your or o			1 🗷 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		remetery c	rematory or other place)	09.27	1	ALTIMORE	
Datumore, IV permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr	once.		21. Signature of Funeral Service I	License		22. Name and Address of IAUGHN C. GRE	Facility FUN	JERAL SE	EVICE	7
	9		23a. Part1. Ente (th) disease, or shock, or he in failure. List	complications that cause	d the death. Do not e	0151 BALTO, NA enter the mode of dying, su				Approximate Interval Between
Physicia	_		Immediate Cause (Final disease or condition	aCo	rang (Intery &	Diseas	0		Onset and Death
/Medic Examin	_		resulting in death)	Due to (or as	a consequence of):	0				
D =	- 1	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Under vin	b. Due to (or as	a consequence of):					
execute n and al-trans		Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
cate be executed physician and the burial-transit		alcai		d						
h certific ending p	(8.4)	0	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
I NECOLUS, F.C. DUX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit		Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4□Pregnant a 9□Unknown		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
that the ed by the detach	Ċ		9 ☐ Unknown Part II. Other significant condition	ons contributing to death t	out not resulting in the	underlying cause given in	Part I.	23e. Did toba	acco use contribute to	o the cause of death?
w requires been signs should be		red by	premios	: mycoa	ndial In	farction		1 🗆 Yes	3 2 □ No 3 □ P	robably 4 Whiknown
e lawri has be		Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
vital nec aician: The law s certificate has b		Φ	25. Was case referred to medical	1		26	. Place of Death (1 ☐ Yes 2	No 1 ☐ Yes	s 2□ No
Of VITA Phyaician: rthis certific ral director,	ŀ	0	examiner? 1 Yes 2 No	Hospital:			_		nce 6 Other (Spe	ecify)
Attending Physic death. ector: After this by the funeral di		ation	27. Manner of Death 1 Datural 5 Pending 2 Accident investig		ury 28b. Time ay Year) Injury	y Work?	2 🗆 No	d. Describe nov	w injury occurred	
or Attender deal		Certification:	3 Suicide 6 Could r 4 Homicide determ	ained 200. Place of In	jury - At home, farm, tc. (Specify)	street, factory, office	28	If. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
spital hours a ineral D			29a. Certifier 1 Certifyin	ng Physician: To the best	of my knowledge, de	eath occurred at the time, d	late and place, an	d due to the car	use(s) and manner a	s stated.
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		Medical	(Check only 2 Medical one)	examiner: On the basis of and manner st	of examination and/or	investigation, in my opinio	on, death occurred	at the time, da	te and place, and due d. Date signed (Moni	e to the cause(s)
7 × 0 0			29b. Signature and title of certifier	- 2 y	Jave	. //	2183		_ i i	005
6			30. Name and address of person	who completed cause of	death (Item 23a) (Typ	e. Print) Marcia	rita B.	Tovel r		
* 1	State	e	2000 West Ba 31. Date filed (Month, Day, Year)	2005 32 Regist	rar's Signature	Sepul 3	y dido	25		
	istra		SEP 2	2 ZUUS	13.1 St. F					

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			giene Reg. N2 0 0 5	31634
	Physicia	2n	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Year	3. Time of Death
	/Medic	ai	Helen Frances			4h Chi Taua a	al continue of Dani	Septemb	oer 23, 2005	
	Examin	er	4a. Facility Name (If not institution, give : 103 Philadelphia I			Joppa	r Location of Dea	ın	Harford	
	Funeral		5. Social Security Number 6. Sex	7. Age	e (in yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt	b 0 Bists	place (State or Foreign
	Director		213-10-2072]м 2 <mark>(</mark> Д) F	81 Yrs.	MOTILIS Days	Hours Min	April 3	30, 1924 Mar	yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary Ind	to	Maryland Harford		Joppa					1 ☐ Yes 2X No
	or 28s	lrec	10e. Street and Number		***	10f. Zip Code			10g. Citizen of What Cou	intry?
	ath wi	ral	103 Philadelphia 1			21085			USA	- Indian
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or Items 23s or 28s-f show event, I'm Marical Evaruicer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ Yh If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	ispanic Origin? (3 an, Mexican, Puel Specify:	specify Yes or No to Rican, etc.)	Black, White Specify:	
21215-0036	72 hou		15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	ation	orkina	16b. Kind of Business/li	
21	- 2 74	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	d)			
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Но	memaker	18. Mother's Na	me (First, Middle,	Own Home Maiden Sumame)	
lan	id be ked o ic eve	To Be		Szukievit	Z		Frances		Sutosh	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other then other treumatic event, Italia		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mail	ing Address (Street	and Number or F	lural Route Numbe	er, City or Town, State, Zi	p Code)
	s 1 and 3 if Health item 27 other tr		Joan Dinsmore - Da	aughter				North E	East, Maryla 20c. Location - City or T	
Jore	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State		osition (Name of matory or other place		1	Bel Air, Ma	
altimore,	그 문문를		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Funeral Service Licens	90		Mem. Gard 2. Name and Addre			Funeral Ho	
ñ	Departing Sany ir		* Russell St.	2	47	1317 Coke	sbury Ro	oad, Abir	ngdon, Maryl	and 21009
L			23a. Part1. Enter the disease, or composition of heart failure. List only or	cations that caused ne cause on each lin	the death. Do not en	ter the mode of dyin	ng, such as cardia	ic or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Myo	cardio	ul int	arcti	on		minutes
	/Medical Examiner			Due to (or as	a consequence of):					
7		ner	if any, leading to immediate	Due to (or as	a consequence of):					
~	cate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	be exelician a	al Ex	resulting in death) Last	Due to (or as	a consequence of):					
687	ficate physics the	edical		j						
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	, . -		23d. Date of deliver Month	∕ery Day Year
Δ.	s that pred b	y Pr	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ords	w require been sig should b	ted	malnut	rition	L			1 🗆 🕆	Yes 2□No 3□Pro	babiy 4 Unknown
Records,	The law rate has be	Completed by						24a. Was autor perfo 1 \(\text{Yes} \)	an 24b. Were autorsy prior to coormed? 1 Yes	opsy findings available ompletion of cause of
Vital	ding Physicien: The h. h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Inin-li		24		eath (Check only c		
of	Physi this c	. To	1 ☐ Yes 2 🗙 No 27. Manner of Death	fospital: 1 ☐ Inpatie 28a. Date of Inju			4 🗀 Nursing	_	dence 6 Other (Spec	ily)
on	Attending Physicien: r death, ector: After this certific by the funeral director,	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Injury	Wor	k? Yes 2 □ No	200. 0030100	now injury occurred	
Division	I or Attendia after death, Director: A i in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, si	treet, factory, office		28f. Location (S City or Tox	Street and Number or Rui	al Route Number,
Ö	itel or A irs after rel Direc led in by									
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical			f examination and/or in				cause(s) and manner as date and place, and due	
	To th withir To th comp	Me	29b. Signature and title of certifier	000	Na V	29c. Licens			29d. Date signed (Month	
)		1 3	Htyllis K.	Tulle	u Mil	1. 1000	14620		Seplember 2	6, 2005
	5			ompleted cause of d	death (Item 23a) (Type 2807 J	rusalem	Rd. H	<i>lingsv</i>	September 2 ille, Md	21087
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	Sant s				
	Regist	rar	SEP 2 9 2	JU5	New St. Ja					

			State of Maryland / Dep. 1 - State Registrar Ce	artment of Health and Me rtificate of Death	ental Hygient	2005 31635
	D 1		1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month Da	3. Time of Death
	Physicia /Medic		Alvertia Marie Jeffers		September	25, 2005 7:00 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	County of Death
	Funeral		1416 Old Joppa Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		B. Date of Birth	Harford 9. Birthplace (State or Foreign
ı.	Director		217-16-0497 1 M 2 XF 85 Yrs.	Months Days Hours Min.	(Month, Day, Year, arch 14,	1920 Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	Maryli f sho	tor	Maryland Harford Joppa			1 ☐ Yes 2 🛣 No
	h the	lrec	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
	ath wil	ralD	1416 Old Joppa Road	21085	USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show emportant: If item 27 is marked other then "naturel", or items 23a or 28a-f show empt injury or other traumetic evant. It is Madical Examither must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Twildowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 🌠 No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	2 hou	ted l	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. H	Kind of Business/Industry
215	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supellife.	s kind of work done during most of working DO NOT use retired) rvisor of Reproduti	on ·	
121	iled w tygier ther th	Cor	12 17. Father's Name (First, Middle, Last)	Center	First, Middle, Maider	S. Government
and	d be fental head of	To Be	Roy David Moxley	Clittis	Albert	· ·
Maryland	shou s mar	-	-	ing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
Σ,	and 2 ealth a m 27 I	3		Oakleigh Road, Bal		
Baltimore,	iges 1 it of H if itel		1 X Burial 2 Cremation 3 Hemoval from State	matory or other place)		ocation - City or Town, State
ᄩ	iit. Pa artmer ortant injury			Mem. Gardens 9/28/ 2. Name and Address of Facility MC		Air, Maryland eral Home, P.A.
Ba	Depariment in poor in poore			1317 Cokesbury Road		
	20		23a/Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. DEMENT	A		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
7		ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying			
V	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c			
8760,	cate be executed obysician and the burial-transit	dical E	bue to (or us a consequence or).			
687	tificate ig phy: as the	ledic	0			
Вох	death certificate be executed e attending physician and of for use as the burial-transit	by Physiclan/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Ö		hysic	1 Yes 2 No 9 Unknown			
rds, P	requires that the death certific een signed by the attending p nould be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Record	The law ite has b page 2 sl	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
/ita	Physicien: Th r this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of	Phys this al dir	. To	1 Yes 2 Hospital: 1 Inpatient 2 □ ER/Outpatie 27. Manner of Death	the second of th	e 5 Residence	6 ☐Other (Specify)
ono	ding Ih. After funer	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	d. Describe now inju	ny occurred
Division	l or Attending after death. Diractor: After I in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	of. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
J	Hospite 4 hours Funerel ely filled	edical Ce	29a. Certifier (Check only one) Description Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one)	th occurred at the time, date and place, an	d due to the cause(s	s) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature an title of Saritier	29c. License number	29d. Da	ate signed (Month, Day, Year)
}	,- > F 0		MY HXX MI)	D36846	SET	TEMBER 26,2005
	17		30. Name and address of person who composed cause of death (Item 23a) (Type Bernard H. Ravitz, MD 5601 Lo	.Print) Ch Raven Rd., Balti	more, MD	21239
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 9 2005 32. Redistrar's Signature	Jane		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 005 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Dorothy Mary Kuhn September 24, 2005 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartlands of Bowie Prince George's Bowie If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours Min Months 057-07-7059 1 □ M 2 □ F 97 March 1, Director 1908 New York Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28a-f shov treumatic event, the Medical Examiner rust be notified at 1∏Yes 2∏No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 7600 Laurel-Bowie Road Items 23e Apt. 101 20715 U.S.A. Pages 1 and 2 should be filed within 72 hours after death is not of Heatlh and Mental Hygiene. Int: If item 27 Is marked other than "naturel", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Faytak Marie Knoshal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth J. Kuhn 9206 Montpelier Drive son Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If any injury or once. Arlington National Cem 10/25/2005 ¹ 4 □ Donation 5 □ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licensee ²²Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration pnuemonia /Medical Due to (or as a consequence of): Examiner Swallowing dysfunction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Advanced age and burial-trar Due to (or as a consequence of): attending physician Box 68760 Physician/Medlcal the as IF FEMALE 981 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Year Dav 4□Pregnant at time of death 5 Other (specify) ed by the detached P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Left Lower Lung Lobectomy Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Masectomy page 2 autopsy performed? Colon resection 1 ☐ Yes 1 Yes 2XX10 2**X**XNo Division of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1XXVatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 15374 09/26/2005 Oi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Faranak Sotoudeh, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 31. Date filed (Month, Day, Year) 32. Sedistrar's Signature 29 2005 Registrar

			For State Registrar	State of Ma	aryland / Dep Ce	ertificate of l			iene20(05 31637
	Physicia		1. Decedent's Name (First, Middle, L. Miri	•	Klein			2. Date of Dea Month 09-26	Day	3. Time of Death Year 6:15a
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Deal		4c. County o	
			Jewish Convales	cent HOME		Pikesvi			Baltin	
	Funeral Director		219-22-1330	Sex 7. Ag 1 M 2 🔀 7	ge (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country) Maryland
3	and d		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	mary	to	Md Carrol	1	Westmins	stor				1 □ Yes 2 No
1	ath with the Malyial 23a or 28e-f show ust be notfiled at	irec	10e. Street and Number		WESCHARIS	10f. Zip Code		1	0g. Citizen of W	hat Country?
1	23a c	aiD	1895 Old Taneyto	wn Road		21158			U.S.A.	
936	lall Hygiene. Ital Hygiene. dother than "natural", or items 23a or 28e-f show event, the Hedical Evarit astrust be rediffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 █ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 1 If Yes, Give Year or Dates:	2,	. Was Decedent of Hill Yes, specify Cuba	ispanic Origin? (9 in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc. White
215-0036	in 72 no in "naturi Medical I	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)		(Giv	edent's Usual Occupa e kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Bus	
2121	Hygiene. ther than " ent, the Mer	mo.	12	College (1-40):	Sa	Les			Retail	
פ	al Hygi d other	Be	17. Father's Name (First, Middle, Las	(t)			18. Mother's Na	me (First, Middle, I	Maiden Sumame)
<u>X</u>		2	Philip Schwartz				Anna V			
	hand hand 7 Ism traum		19a. Informant's Name/Relationship Kim Klein	(Type, Print) (Daughter)		ling Address (Street a			-	State, Zip Code) Maryland 21158
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition	(Isaugireez)	20b. Place of Dist	osition (Name of	1			City or Town, State
ᅙ	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Garrison	ematory or other place	1	3/2005 0		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	•		22. Name and Addres				ral Directors
Ö	20 1 20	[[]	1 Course			8728 Libe:				Maryland 21133
	hysician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused y one cause on each li	d the death. Do not e	nter the mode of dyin	g, such as cardia	c or respiratory arm	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	,				1 1415.
V :	Juled J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events	b. — Due to (or as	a consequence of):					
3760,	cernicate be executed ding physician and rise as the burial-transit	lical Exa	resulting in death) Last	Due to (or as	a consequence of):					
ĕ.	dearn cerrino e attending p id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy			23d. Date Mont	of delivery th Day Year
rds, P.	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did tol		bute to the cause of death?
<u>ش</u> ,	о <u>г</u>	Completed						24a. Was a autops perforr	y ned2 pr de	ere autopsy findings available ior to completion of cause of sath? Yes 2 No
Vita	ysician: In is certificate director, pag	Be C	25. Was case referred of medical examiner?				26. Place of De	ath (Check only on		
	this ce al dire	၉	1 □ Yes 2 12 No	Hospital: 1 Inpatie			4 ursing i	Home 5 Reside		
Division of	After 1	ion:	27. Man er of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) lnjury	Worl		28d. Describe ho	w injury occurre	d
Sic	tor: the	icat	2 Accident investigati 3 Suicide 6 Could not	be an Place of Ini	jury - At home, farm, s		Yes 2 □ No	28f. Location (St	reet and Number	r or Rural Route Number,
	after deatl after deatl Director: d in by the	Certification;	4 Homicide determine	building, et	tc. (Specify)	ricot, raciory, cirico		City or Town		or raid rodo ransor,
:	To the Hospitel of Al within 24 hours after of To the Funerel Direc completely filled in by	edicai C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best aminer: On the basis o and manner st	of examination and/or	ath occurred at the timinvestigation, in my of	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
,	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier		Α	29c. Licens	number	2	9d. Date signed	(Month, Day, Year)
	1		Hru XI	noline	MO		11514	0 2	SET.	26,200
	5		30. Name and address of person who	o completed cause of c	de nh (Item 23a) (Type	Print) Or	HAT A	A R	Ann A	10 2016
			31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	10 12	1112.10	vc, 1)	114/10	11/15
	Sta Registi		SFP 2 9 201		J. Sa	ele				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment			and M	ental Hy	giene	05	316	38	
			1. Decedent's Name (First, Middle, Las	t)			-				2. Date of Dea Month	ıth	V	3. Time of	Death	
	Physici /Medio		Nora J. Kopec								Septemb	er 26,	2005	4:4	5 A ^M	
	Examir		4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. County	4c. County of Death			
			123 Dale Road				Pasac	_	W I to do.	04.11		Anne Arundel				
г	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex	Age (In yrs.	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	r, Year)	9. Birthp Coun	place (State o	r Foreign	
			214-01-6484 Usual Residence of Decedent		09						May 31	, 1916	Mary	Land		
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	U					1	0d. Inside Ci	ity Limits	
	a-f si	ctor	Maryland Anne Arur	del		Pasade	ena							1 🗆 Yes	2∏No	
	ith the	Director	10e. Street and Number				10f. Zip	Code	_			10g. Citizen of	What Coun	itry?		
	in 72 hours after death with the Marylan "naturel", or Nems 23e or 28a-f show offical Examirer must be mailfied at		123 Dale Road					122				Unite	ed Sta	ites		
	er de Items	Funeral	11. Marital Status	12. Was Decede	es?	.S. 13.	Was Decedent 1 Yes, spec	ent of Hi ify Cubai	spanic Orig n, Mexican	gin? (Spe ı, Puerto l	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ ck, White,			
21215-0036	rs aft	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2: If Yes, Give Year or Date			1 ☐ Yes 2X No Specify:					Specif	y. Whi	te		
	within 72 hours after death with the Maryland one. then "naturel", or items 23e or 28e-f show he Medical Examiner must be mullified at	ed	15. Decedent's Education 16a. Decedent's Usual Occupation							16b. Kind of Business/Industry						
215	d within 72 ho piene. r then "natur ine Modical	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)						ng							
21	77 (2) 10 10	Con	7	0			Line V	vorke	er			Manufa	cturi	ng		
nd	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,					
yla	2 should be and Mental le marked o	2	Ludwig Kopec						Agnes							
Maryland	2 sh and le m reum		19a. Informant's Name/Relationship (7								I Route Numbe				0	
	ges 1 and 2 should be filed tof Health and Mental Hyg If item 27 le marked othe or other treumatic event,		Bernard T. Kopec - 20a. Method of Disposition	son	20h P						e, Dacu	20c. Location		30019	9	
סר	ages nt of t		1 Burial 2 Cremation 3 🗆		110	lace of Dispo emetery, cren									_	
Baltimore,	it. P.		 4 ☐ Donation 5 ☐ Other (Specify 21. Signate of Funeral Service ∯cen 		LOI	udon Pa			e of Facility	9/30	/2005	Baltimo	ore, M	larylar	nd	
	permit. Pages Department of the Importent: If its any injury or of once.		Inn 4	Zink)	1.	107 174	lleo	oo 7	' Hub	bard Fu , Balti	neral H	lome,	Inc.	220	
	American be executed // Medical // Medical Examiner // Italian and the purial-transit	Examiner	shock, or heart failure. List only one cause on lach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of final disease) Sequentially list condition b.									Approximate Interval Betv Onset and D	ween			
8760,	sician burial	dical E	resulting in death) Last													
9	ificate g phy as the	o.														
.O. Box (that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Nas decedent pregnant n the past 12 months? ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3					□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year		
<u>α</u>	The law requires that the tee has been signed by the bage 2 should be detache	by Pl	Part II. Other significant conditions or	ntributing to deat	h but not resu	ulting in the ur	derlying ca	use give	n in Part I.	ð	23e. Did to	bacco use cont	tribate to th	e cause of de	eath?	
rds	w require been sig should b	Eluone atrial willation Hypothymia 1 Tes 2 PNo								es 2.⊡No	3 🗌 Proba	ably 4 □U	Inknown			
000	ie law requ has been ge 2 shoult	Completed						24a. Wa:								
m m	The I	Com							autops perform	ned?			tuse of			
of Vital Records,	icien: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or					
× ×	Physicien: r this certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa		ER/Outpatien	nt 3 DOA Other: 4 Nursing Home 5 ≪ Residence 6 Dother (Specify)									
Division	vtending Physicien: death. ctor: After this certific y the funeral director,	catlon:	27. Manner Death 1	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No					8d. Describe ho	be how injury occurred						
	or At	Certification:	4 Homicide determined		(Specify) City or Town,					reet and Number or Rural Route Number, , State)						
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsicien: To the be iner: On the basis and manner	s of examinat	wledge, death tion and/or inv	occurred a restigation, i	t the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the cod at the time, d	ause(s) and ma ate and place, a	anner as sta and due to	ated. the cause(s))	
	o the	Med	29b. Signature and title of certifier	a mamor) -	29c.	License	number		2	9d. Date signed	d (Month, E	Day, Year)		
	->-0		Van Mar	7 13	TENO	NG		1)	16 2	00	5	ep Tem	6000	27,21	200	
			30. Name and address of person who o	ompleted cause of	of gleath (Item	23a) (Type, I	Print)	1	-			7				
	3		N.M. MACHIRA	0 720.	CMA	DENC	Lierc	e L	14, C	AT	ONSVIL	le MI	0 21	228		
	Sta	-	31. Date filed (Month, Day, Year)	_ #	strar's Signal		de		7							
	Registr	ar	SEP 2 9 200	J DER	3.1 3.3	2										

CPM05-066510 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27.perME_6848,10/26/05 TT epartment of Health and Mental Hygiene JAMES KELLER 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 23, **Physician** 2005 JAMES EDWARD KELLER 16:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5517 Harford Road Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y 8/2/1943 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours 212-44-3352 Director 62 MARYLAND Usual Residence of Decedent Manyland 10c. City. Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5517 HARFORD ROAD 21214 USA Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 777 F77N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: VIETNAM WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) YEARS POLICE OFFICER BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked of MILLARD W. KELLER, SR. MARIE O'BRIEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 Is any injury or other trau ones. BONNIE KELLER/WIFE 21 KING CHARLES CIRCLE ROSEDALE, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of DULANEY COTATO COTO MEM. Burial 2 ☐ Cremation 3 ☐ Removal from State 9/28/2005 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a.1 art1. Entry The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tarry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner physician and s the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the a o 9 Unknown signed by the Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b lirector, page 2 s autepsy performed? death? 1 Yes 2 No 2 No Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{QOther} \(\text{(Specify)} \) SCENE 1 Yes 2 □ No Certification: To 27. Manner of Death 1 Alatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 24, 2005 Minte of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 2005

TRUBBUR

32. Registrar's Signature

ORIGINAL

KOBEL

a.m

2005

SEPTEMBER 28,

MARY KELLER

			1 - For State Registrar	State of Maryla		ment of H			giene og. Na 200	 5 3161.1		
		ġ.	Decedent's Name (First, Middle, La						Date of Death 3. Time of Death			
	Physic /Medi		LORRAINE	Luc	AS			SEPTEMB	ER 23 20			
4	Exami		4a. Facility Name (If not institution, gi			b. City, Town, or	r Location of Dea		4c. County of D	eath		
40			HARBOR HOS P 5. Social Security Number 6.			f Under 1 Year	If Under 24 Hr		/	UA		
*	Funeral Director	ď		1□ M 2 X F		Months Days	Hours Mir		Year) 9. 1 91925 N	Birthplace (State or Foreign Country)		
	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28a-f show ha Madical Exertires. The benotified at	_	10a. State 10b. County	10c. (City, Town or Locat	ion				10d. Inside City Limits		
	ith the Marylar or 28a-f show	Funeral Director	MARYLAND N	IA		BA	LTIM	ORE C	174	1/Q Yes 2 □ No		
	with t	D	10e. Street and Number	40.10.15	-	10f. Zip Code	911	13	0g. Citizen of What	•		
	death ms 23	era	11. Marital Status	12. Was Decedent Ever in	2 5 7. U.S. 13. Was	s Decedent of H	ispanic Origin? (Specify Yes or No- rto Rican, etc.)	US/	merican Indian,		
9	after or ite	Ful	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			an, Mexican, Pue Specify:	rto Rican, etc.)	Black, W			
5-0036	hours tural',	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: 2	UHITE		
215-	n nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent (Give kind life, DO	t's Usual Occupa d of work done o NOT use retired	ation during most of wi f)	orking	16b. Kind of Busine	ss/Industry		
212	d with giene ar the	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			AKER		OWN	Home		
	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exertinetry ust be notified at	Be	17. Father's Name (First, Middle, Last	,			18. Mother's Na	me (First, Middle, I	Maiden Sumame)	MN-UNKNOWN)		
Maryland		^C	1316		CAS		VIRC	FINIA				
Ma			19a. Informant's Name/Relationship	Type, Print)	19b. Mailing A	Address (Street a	- 4		City or Town, State			
ē,			20a. Method of Disposition	I	Place of Disposition	on (Name of	TIMOV	Date	20c. Location · City	Mb. 21213 or Town, State		
m o	g = 5		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cremato 1ETRO C		O) .	4		YORE, MD.		
Baltimore ,	permit. Pa Departmen Important: any njury once.		21. Signature of Fun ral Service Lice	nsee	22. No	ame and Addres	s of Facility	BROWN	JR, Fui	VERAL Itome		
	20539		Jan .	V. 10	700	140 N	. FULT	ON AVE.	XOALTO,	4021217		
	Physician /Medical Examiner		Immediate Cause (Final	Onset and Death								
			disease or condition resulting in death)	Due to (or as a consequence of):								
		L	Sequentially list conditions,	HOSPITAL ACQUIRED PNEUMONIA ZWEELS								
14		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
1,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c	equence of):							
8760	sate be executed physician and the burial-transit	dicai	(d								
9	artifica ing ph e as th	Med	IF FEMALE:									
Вох	death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1						delivery Day Year		
o.	t the de by the a	nysic	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of 9□ Unknown	death 5∐Oti	her (s <i>pecify</i>)			Month	Day Faai		
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions	contributing to death but not re	sulting in the under	lying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?		
of Vital Records,	w require been sig should b	ted t						1 ☐ Ye	s 2 No 3	Probably 4 Unknown		
ecc	las be	Completed						24a. Was ar		autopsy findings available o completion of cause of		
E H	cate ha							perform		? `		
<u>\$</u>	Physicien: or this certific oral director,) Be	25. Was case referred to medical examiner?	Hospital:	☐ER/Outpatient 3	Othe		ath Check only one				
ō		n; To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28c. Injury Work	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
Ö	Attending I r death. ector: After by the funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) n								
Division	l or Atte after de Directo I in by th	rtific	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At building, etc. (Spec	factory, office	28f. Location (Str.	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	Hospitel c											
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) (Check only one)	nysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death occ nation and/or investi	curred at the tim- gation, in my op	e, date and place sinion, death occi	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)		
	To the within To the compli	Me	29b. Signature and title of certifier	t d		29c. License	number	29	d. Date signed (Mo	nth, Day, Year)		
	^		▶ Abdulta	literaje		RES	00 1	SEPTEMBER 23, 2005				
	2		30. Name and address of person who		em 23a) (Type, Print	t)	a- :-					
			ASDUL ADJE! 31. Date filed (Month Day, Year)	3001 SOUTH	HANOU	tk SII	KEET,	BALTIMO	RE MARY	LAND 21225		
	Sta Registr		31. Date filed (Month Day, Year) 2	32 Registrar's Sign	A Angel	En S			40,			

JC 05**-**06563 Esth

ner	Byrne	La	1U For State Registrar	State of Ma	ryland / Dep		lealth an	d Mental Hy	9	05	31642	
	District Section 1		1. Decedent's Name (First, Middle, La	ıst)				2. Date of De Month	ath	Voor	3. Time of Death	
3	Physici /Medi			Esther By	rne Lau				September 26,2005 10:			
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of D	eath	4c. County	of Death		
***		36	3140 Wilkens Ave 5. Social Security Number 6.5		(In yrs. last birthday)	Baltimor If Under 1 Year	If Under 24	Hrs. I a D (Die	1	0.01		
ja;	, Funeral Director			I M arx E	78 Yrs.	Months Days		Hrs. 8. Date of Bir Month, Da Apr 08	y, Year)	9. Birthp Coun	lace (State or Foreign try) ralia	
46	D		Usual Residence of Decedent					TIPE 00	, 1021	TIQD C.	rarra	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department if them 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	_	10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits	
:		octo	MD Baltimore								1 X Yes 2 No	
		Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
		eral	3140 Wilkens Ave	nue 12. Was Decedent E	iver in U.S. 13	21223	diapania Origini	7 (Chasifu Van as Na	U.S.A.	na Amaria	an Indian	
36		by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Amed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	0	was Decedent of P If Yes, specify Cuba 1 ☐ Yes 2 💆 No		? (Specify Yes or No uerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	eal E	ed	15. Decedent's E		16a. Dece	dent's Usual Occup	pation		16b. Kind of B			
215	nin 72 no "ou Media	Completed	(Specify only highest gr.	ade completed) College (1-4or 5-	(Give	kind of work done DO NOT use retired	during most of	working		301110031110	a day	
7	d wit	Com		2	Loca	tor			State	Gove	cnment	
b D	d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	e, Maiden Surname)			
<u> </u>	Ment Ment arkec	2	Leo William Nels				Lucil	le Matilda	a Bree			
Jar Jar	2 sh and ls m		19a. Informant's Name/Relationship (,				r Rural Route Numbe			,	
e) .	Pages 1 and 2 ment of Health ar ant: If Item 27 Is lury or other trau		Bryan Lau 20a. Method of Disposition	/son	20b. Place of Dispo		od Terr	ace, Laure				
Baltimore,			1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	(y)	cemetery, crea	natory or other place	-		20c. Location -			
Ball	Depart Depart Import any in		21. Signature of Funeral Service Lice	111		2. Name and Addre Donaldsor 313 Talbo	ı Funer	al Home, I . Laurel,	P.A. Marvlan	nd 207	707-4389	
*	hysician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. ATHEROSCUERATIC (ARDIO ARWAR PISEASE)									
	/Medical xaminer	ılner	disease or condition resulting in death)	Due to (or as a	consequence of):	ce Oth	2010 14	18 WAR	PISE	BJE		
	nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
760,	ysician and he burial-transit											
	ing physics as the c	Medical										
P.O. Box	irres that the death certifical signed by the attending phy d be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2	3c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year		
٦ .	mar ned by deta	y P	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?	
rds	qures n sign							1 🗆 Y	′es 2□No	3 ☐ Proba	ibly 4 Ninknown	
Vital Records,	s been si should I	lete						24a. Was	an 24b. \	Nere auton	sy findings available	
2	te has	Se Completed						- autop	rmed?	prior to con death?	pletion of cause of	
<u>ta</u>	To the most read of the form o		25. Was case referred to medical				26. Place of I	1 ☐ Yes Death (Check only o		Yes	2LI NO	
>		To B	examiner? 1∰ Yes 2 □ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatier	t 3 DOA Oth	05	g Home 5 ☐ Resid	b.	er (Specify	Scene	
Division of		atlon; T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	yat k? Yes 2 □ No	28d. Describe h	28d. Describe how injury occurred						
Divis	al or Atte safter des l Directo d in by th	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	to the mospinal of Attentions within 24 hours after death. To the Funeral Directors After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Pr (Check only one)	nysician: To the best of miner: On the basis of a and manner state	examination and/or in	n occurred at the tin vestigation, in my op	ne, date and pl pinion, death o	ace, and due to the occurred at the time, o	cause(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)	
	withir To th	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, D	Pay, Year)	
)			0.C.M.E. September 27, 2005									
	10		30. Name and address of person who	310,40	111 Penn	*	Baltimo	ore, Maryl	and 212	01		
	Sta Registr		SEP 2 9 2	005 32. Registrar	's Signature	reels)						
DHM	H 17 Rev 1/2	001			ORIGII							

State of Maryland / Department of Health and Mental Hygiene 0 0 5 31643 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Joseph Edward Lewellyn, Jr. September 25, 2005 /Medical 8:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3200 Woodspring Drive Abingdon Harford 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month. Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 579-48-2650 71 Yrs. 1934 March 22, California Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked othar than "natural", or items 23a or 28a-f show othar traumatic evant, the Medical Examinar must be mulified at 1 Yes 2 No Director Maryland Harford Abingdon 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? death with 3200 Woodspring Drive 21009 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:1956-58 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked othar than "natural", or Iter Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Abestos Insulator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Edward Lewellyn, Sr. Geneva Louisa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is rr any injury or othar traum <u>once</u>. Jeanette L. Lewellyn - Wife 3200 Woodspring Drive, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial / 2 ☐ Cremation 3 Removal from State `4 □Denation 5 □ Other (Specify Hilltop Service Corp. 10/03/05 Towson, Maryland 21. Signatu Service Lice 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NO cancel van /Medical Due to (or as a cons que ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (United to 1 july) Due to (or as a consequence of): Examiner burial-transit certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1□ Yes 1 Tes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home St Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕱 No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of entitier 29c. License number 29d. Date signed (Month, Day, Year) D0061040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD PLD (0 31. Date filed (Month, Day, Year) SEP 2 32 gegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 ANTHONY MCCRAY 31644 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANTHONI SEPTEMBER 24,2005 10:43P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) Year 1X M 2□ F 3 Months Days Hours 文 213-80-6409 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow trsumatic event, the Madical Examiner must be notified at Director 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 40 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🗷 No Specify: Completed by 3 Widowed 4 Divorced ACK "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) TH GRADE LABORER FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BROG ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is eny injury or other tratonce. ST, CALTIHOR MD 2/2/
Date 20c. Location - City or Town, State MARGARET LEE MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition DBurial 2 ☐ Cremation 3 ☐ Removal from State ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE MARYLAND 22. Name and Address of Accility BROWN

JOSE PH H. BROWN

AVE 21. Signature of Fun ral Seprice Licensee JR. FUNERAL HOME 23a Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) MULTIPLE STAB AND CUTTING WOUNDS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) bed i 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ been si 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete has blirector, page 2 s autopsy performed? 'es 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation roseased death. -24-06 ZZ:00-PM 1 Yes 2 No Stabbec within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 2300 ELL Division 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Strol To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the of certifit 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E SEPTEMBER 25,2005 person who combleted cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of Marylan		artment of H tificate of I			Reg. No U	05 31645
Phy	/sicia	_	Decedent's Name (First, Middle, Last) MARY LEE I	MCKINNEY				2. Date of Dea Month		3. Time of Death Year 2005 1:55 a M
	ledica amine		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of De		4c. County of	
EX	amme	2	20 Post Office Aver			Laurel			Princ	e George's
Fun Dire	_		5. Social Security Number 6. Sex 1	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Hrs. 8. Date of Birt Min. (Month, Da Sept 2	y, Year)	9. Birthplace (State or Foreign Country) Maryland
and	25	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation			-	10d. Inside City Limits
Maryl -1 sho	a bed	to	MD Prince Ge	eorge Lau	rel					1 ⊋Yes 2 □ No
h the	ilon a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
ath wit	qian	a D	20 Post Office Ave	enue		20707			U.S.A.	
er dea	BEE	Funerai	Tr. Wallar Glates	Was Decedent Ever in U. Armed Forces?	.S. 13. Y	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race Black	- American Indian, k, White, etc.
J36 urs aft	T. B.	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	White
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28e-f show	Enle	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation during most of	workina	16b. Kind of Bu	siness/Industry
12. If in in in in in in in in in in in in in	N S	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	_	kind of work done of DO NOT use retired	1)		D-+	<i>E</i> :
nd 2121 e filed within al Hygiene.	표	ပ္ပ	12 17. Father's Name (First, Middle, Last)		Surve	yor	18. Mother's	Name (First, Middle,	Ratings Maiden Sumame	
d as b		To Be	Edward Harding				Bessie			,
re, Maryland s 1 and 2 should be file if Health and Mental Hy Item 27 is merked oth	umatl	F	19a. Informant's Name/Relationship (Typ	рө, Print)	19b. Mailir	ng Address (Street	and Number or	r Rural Route Numbe	er, City or Town,	State, Zip Code)
	er tre		Grover F. McKinney		_		ce Aven	ue, Laure		
Baltimore, permit. Pages 1 ar Department of Hea mportent: If Item?	or oth	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crei	sition (Name of natory or other plac		Date		City or Town, State
timent rtent:	Jury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licence		the second secon			p 30, 05		Maryland
Baltimore permit. Pages 1 Department of H Importent: If Ite	any ir		21. Signature of Funeral Service License	M007				1 Home, P		20707-4389
			23a. Part1. Enter the disease, or complice shock, or heart tailure. List only on	ations that caused the deat						Approximate Interval Between Onset and Death
- Pnysid /Med			Immediate Cause (Final disease or condition resulting in death)	Colon Cance						l year
	aminer				derice or,					
	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
A pecuted	the burial-transit	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a conseq	uoneo of):					
760, te be ex ysician a	burial			Due to (or as a conseq	derice or).					
687 ificate	s the	edica	d							
ecords, P.O. Box 68760, < law requires that the death certificate be executed as been signed by the attending physician and	for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna		Ectopic pregnancy	,			e of delivery
O. B e deatl he atte	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐ Pregnant at time of d		Other (specify)			Mor	nth Day Year
P.O. hat the de	detached	Phy	9 ☐ Unknown Part II. Dther significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the cause of death?
Vital Records, sicien: The law requires to certificate has been signe	9	d by						10	Yes 2 🛣 No	3 ☐ Probably 4 ☐ Unknown
COL w requ	should	Completed						24a. Was		Vere autopsy findings available
Re(The lavate has	page 2	шо						— autor performance 1 ☐ Yes	rmed? d	rior to completion of cause of leath? □ Yes 2□ No
Vital Fidicien: The contificate	director, p	BeC	25. Was case referred to medical examiner?					Death (Check only o		
of Vital Physicien:	0	2	1 ☐ Yes 2XX No		ER/Outpatie		4 🔲 INUISII	ng Home 5 N Resi	dence 6 Othe	
Jing F	funer	tion:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No	28g. Describe	now injury occurs	90
Division of or Attending Phy after death. Director: After this	in by	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st fy)			28f. Location (i City or Tot		er or Rural Route Number,
To the Hospitel within 24 hours a	completely filled in by	edical C		sicien: To the best of my knoner: On the basis of examina and manner stated.						
To the within 2	omple	Med	29b. Signature and title of certifier	11111		29c. Licens	e number			(Month, Day, Year)
F 5 F	O		I Timoth .	Myllin !	MD	D	395	32	9/2:	8/2005
	,0		30. Name and address of person who co Timothy P. McClai			Print)		rel, MD 2		
	Sta egistr		31. Date filed (Month, Day, Year)	32. Registrade Signa 2005	ature					

Amend Item 18 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Malone 2005 Cilonia plember 22 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner CHY ELLICOTT HOWARD MILLENIUM NURSING HOME Hours Min. 8. Date of Birth (Month, Day, Year)

Ob. 22. 1923 Birthplace (State or Foreign Country) ff Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months **Funeral** Days 1 M 200 F Yrs. 197.16.3552 82 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mantal Hygiena. Important: if them 27 is marked other than "natural", or thems 23a or 22a.4.1.20R.8. 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 Tyes 2 No No Director ELLICOTI CITY MD HOWARD 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21043 USA RUN 8418 GOVERNORS Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC YRS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) LASSIE REAWS Lasse Reavis VALROID AUSTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) 3512 DENNLYN RD., BALTIMORE, MD MARCIA BROWN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CRESTLAWN 09.30.05 MARRIOTTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical A12 hemmer Examiner Physician/Medical Examiner or Attending Physician: The law requiras that tha death certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 thknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D30641 September 28 2005 Back River Neek Road Baltimure Mayland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamesh Sabapalhi 201-109 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar

			For State	i icas	State of	f Marylar		artment of I						216	- 1
			Registrar 1. Decedent's Name (Fi	rst, Middle, L	ast)		Cei	rtificate of	Death		2. Date of Dea	Reg. No.		3. Time of D) Li Death
	Physicia /Medic	_	JEANETE		RTIN						109. 23	200C	5 Year	7:50	Ам
J	Examin		4a. Facility Name (If not	institution, g	_	ENUE		4b. City, Town, or BALTIM		of Death		4c. 0	County of Death	n	
	Funeral		2646 EDN 5. Social Security Numb		Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da)	h v. Year)		nplace (State or untry)	Foreign
	Director		217 · 20 · 17 ·		1□M 2 ⊠. F	83	Yrs.	Months Days	Hours	191111.	10.03.	1921		NC	
	yland			b. County		1	ty, Town or Lo							10d. Inside City	
	Ba-f s	Funeral Director	MD	N	A	BA	LTIMOR	10f. Zip Code				10g Citiz	en of What Co	1 N Yes	2 NO
	3a or 2	Dir	10e. Street and Numbe 2LAL EDN		SONI A	VENUE		212	23			rog. Citiz	USA	untry r	
	r death	nera	11. Marital Status	10.00	12. Was Dec	edent Ever in U orces?	J.S. 13.	Was Decedent of	Hispanic Or pan, Mexica	igin? (Spen, Puerto	ecify Yes or No- Rican, etc.)	. 1.	4. Race - Amer Black, White		
0000	urs afte	by Fu	1 ☐ Never Married 3 🗷 Widowed 4 ☐		f 1 ∐ Yes If Yes, G Year or D	ve		1 ☐ Yes 2 🕱 No	Specify:	:		5	Specify: BL	ACK	
ה ה	72 hours after death with the Marylar "naturel", or Itams 23a or 28a-f show alical Examiner must be notified at		15. (Specify o	Decedent's	Education grade completed;		(Give	dent's Usual Occu kind of work done	durina mos	st of work	ing	16b. Kin	d of Business/I	industry	
7	filed within 72 hours after death with the Maryland I Hygiene. other than "naturel", or Itams 23a or 28a-f show rent. I've Medical Examiner must be notified at	Completed	Elementary/Seconda		College (1-4or 5+)	1	DO NOT use retire	,			HAIF	R CARE	=	
and	m = 0 %	BeC	17. Father's Name (Firs	t, Middle, La	st)		.!				e (First, Middle,				
Va		To	FREDRICK 19a. Informant's Name	VAUG			19h Mailir	ng Address (Stree	LI LL		al Route Numbe	er City or	Town State 7	(in Code)	
Z	2 s - 2 s - 1 s -		RONALD G			(noe		NORTH H			BALTO			_	
ore,	Pages 1 and nent of Health int: If item 27 iry or other t		20a. Method of Disposi 1 Burial 2 □ C		☐Removal from	State	cemetery, crei	sition (Name of matory or other pla			Date		ation - City or		
бащтоге	permit. Pages Department of Important: If i any injury or once.		4 □Donation 5 □			CE	DAR H				8-05		70. MC)	
ğ	Depa Impo any i		> 2 angl	in (51	Name and Addr NUGHN C. 51 BALIO	NATU P	IKE.	BALTO,	WD:	21229		
	Physician /		23a. Part1. Enter shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	ilure. List on	a	caused the dea each line.)ehy	drat	ing, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Betwonset and Do	reen
	Examiner	L	Sequentially list condit	ions,	b. —	0		an C	anc	er				Moni	this
0	nsit ted	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or injury)	10	Due to	(or as a consec	quence of):								
α Σ	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last		c Due to	(or as a consec	quence of):								
8/60,	w ~ w	dicai			d										
O. Box 6	res that the death certificate signed by the attending phys be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent proving the past 12 mo 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2	nths?	1 ☐ Live	utcome of pregn birth 2 Fet mant at time of nown	al déath 3 🛚	Ectopic pregnand Other (specify)	су			2:	3d. Date of deli Month	,	ear
ລົ ກັ	requires that the een signed by th hould be detache	by Ph	Part II. Other significa	nt condition	s contributing to	1.7		inderlying cause g	iven in Part	ł.			,	the cause of de	
ecord	requi			recif	s Keray	Vasi	ular	Wie	ale			/es 2 ₽		obably 4 🗆 Ur	
r	The lay ate has page 2	e Completed	25. Was case referred	to madical	men	7a			76 Place	o of Deat		rmed? 2 No	prior to death?	topsy findings a completion of ca	use of
r Vital	> .º 0	To Be	examiner?	, induiting	Hospital:	Inpatient 2] ER/Outpatie	nt 3 DOA	the name		ome 5 esid		☐Other (Spec	cify)	
no or	ftel ne			Pending		of Injury nth, Day Year)	28b. Time of Injury	W	ury at ork? □ Yes 2 □		28d. Describe I	now injury	occurred		
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident 3 Suicide 4 Homicide	investiga Could no determin	t be 28e. Place	e of Injury - At I ding, etc. (Spec	nome, farm, st	reet, factory, office			28f. Location (S City or Tox		l Number or Ru	ıral Route Numb	101,
	he Hospite n 24 hours he Funerel oletely filler	Medical C	29a. Certifier 1 (Check only one)	Certifying Medical Ex	kaminer: On the	e best of my kn basis of examin nner stated.	lowledge, deat lation and/or in	h occurred at the livestigation, in my	time, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
)	To t To the	Σ	29b. Signature and title	a of certifie	27	Ane	2mg:N1	29c. Licer	D (7112	8	Sef	signed (Montl	n, Day, Year)	5
	N		30. Name and address	Sch	WASTZ	M.D	3517	Print) Dewl	anil	Rel	21	218	}		
	Sta Regist		31. Date filed (Month,	Day, Year) SEP 2	9 2005 32.	Registrar's Sign	nature	Granis							

ORIGINAL

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere of the

	State of Mary	Certificate of	Death		31649
	Decedent's Name (First, Middle, Last)		2. Date of E		3. Time of Death
Physiciar /Medica	Margaret Virginia Mil:	ler	Sep.	28, 2005	9:05AM
Examine	4a Facility Neme (If not institution, give street and number)		4b. City, Town, or Location of Dea	ath 4c. County of Dee	
	Future Care Cherrywood		Reisterstown	Baltim	
Funeral Director	1 M X X F	Vrs Months Days	Hours Min. (Month, L		irthplace (State or Foreign Country)
D	Usual Residence of Decedent	3	nec.	7, 1921 Ma	aryland
anyten show		Oc. City, Town or Location			10d. Inside City Limits
ha Me 28a-1	MD Baltimore	Reisterstown		·	1 ☐ Yes XXX No
with t	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	
5 itar death with tha Ma ritens 23e or 28e-1 s iner must be notified	4912 Pleasant Grove Rd. 11. Marital Status 12. Was Decedent Ever		1136 Hispanic Origin? (Specify Yes or N	U.S.A 14. Race - Am	
S	3 ☐ Widowed XX Divorced If Yes, Give Year or Dates:	If Yes, specify Cub	Hispanic Origin? (Specify Yes or Noan, Mexican, Puerto Rican, etc.) Specify:	0	
ind 21215-01 be filed within 72 hou lei Hygiena. d other than "natura event, the Medical E	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu	during most of working	16b. Kind of Business	s/Industry
vithin na.	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retire	9d)		
The Hygie of the Hygie	6 17. Father's Name (First, Middle, Last)	Factory Wo	orker 18. Mother's Name (First, Middle	Clothin	ng
E Sec 2	Charles Walter Harvey		Margaret S		
Should should wan Man Man Man Man Man Man Man Man Man M	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street	it and Number or Rural Route Num		Zip Code)
	Thomas Miller / Son	The second second	ns Ln.; Reiste		
or He He He He He He He He He He He He He		20b. Place of Disposition (Name of cemetery, crematory or other pla	Date	20c. Location - City or	
SAITIMOTE, emit. Pages 1 ar epartment of Hee moortant: if Item. iny Injury or other	4 □ Donation 5 □ Other (Specify)	leasant Grove (Cemetery 10/1	/05 Reiste	erstown,MD
Demit Depart Import any In	21. Signature Tryleral Strvice Licensee	22. Name and Addre	ess of Facility Eckhardt	Funeral C	hapel P.A.
40294	thehard frum		sterstownRd.		1s,MD21117
	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter the mode of dying	ng, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final	maline and	11.		1. /
Examiner	disease or condition resulting in death)	Urdin arch	y/amia		arburan
	Due	to (or as a consequence of):	1		
D&/ DU, licate be axecumon physician and stranger is the burial-transit edical Examiner	Sequentially list conditions, Due	to (or as a consequence of):			
be axe citan a buntat	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
death certificate be assed death certificate be assed e attending physician and of for use es tha burlal-tra sician/Medical Exa		to (or as a consequence of):			
# Q10 =	d				
at the death cell by the attendiate for use	Part II. Other significant conditions contributing to death but no	nt resulting in the underlying cause di	ven in Part I 23b. Did	tobacco use contribute	to the cause of death?
at the stacke stacke	1. 1.				Probably 4 Unknown
ras the ras the signed be de	(on plenting)	, r			
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after deeth. To the Funerial Director: After this cartificate has been signed by the attendir completely filled in by the funeral director, page 2 should be datached for use Medical Certification: To Be Completed by Physician/A	1 Junes tin		24a. Was	formed?	Were autopsy findings available prior to completion of cause of death?
The The sate h page			10	Yes 2 No	1 ☐ Yes 2 ☐ No
clan: T	25. Was cese referred to medical examiner? Hospital:	L Out	26. Place of Death (Check only		
Physic this c ral dire	1 Inpatient	ZLI EN Outpatient 3LI DOA	her: 4 Nursing Home 5 Res		cify)
ding I	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Dey Yea 2 ☐ Accident investigation		ry at 28d. Describe rk?] Yes 2 □ No	how injury occurred	
Atten r deet by the	3 Suicide 6 Could not be determined 28e. Plece of Injury -	At home, farm, street, factory, office	28f. Location ((Street and Number or Ru	ural Route Number,
tal or Attending P rs aftar deeth. al Director: After i led in by the funer Certification:	4 ☐ Homicide determined building, etc. (Sp	oecify)	City or 10	iwn, State)	
he Hospit in 24 hour he Funera pletely fille	29a. Certifier (Check only Check only C	knowledge, death occurred at the tin	me, date and place, and due to the	cause(s) and manner as	s stated.
thin 2, the Formplet	one) and manner stated. 29b. Signature and title of centifier	29c. Licens			
5 2 5 8 —				29d. Date signed (Month	
A	30. Name and address of person who completed cause of death	(Hom 23a) (Tune Print)	1367	91010	1)
7 为	Allen Authenream	(Item 23a) (Type, Print) h 1838 G	7569 Frem Tree	Rel 7	21750
State	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	12 1100	, , ,	1008
Registrar	SEP 2 9 2005	M. Beach			

DHMH 16 Rev 6/95

ORIGINAL

			for State Registrar	State of Ma	ıryland	-	artmen rtificate					giene	- 10 Mar	15	31650	7
	Physic /Medi		Decedent's Name (First, Middle, La Anna M. Mayr								2. Date of De			Year 05	3. Time of Death	M
	Exami		4a. Facility Name (If not institution, gir Bel Air Heath 5. Social Security Number 6.) and R	ehab (In yrs. Ias	t birthday)	4b. City, Be If Under	11	Location o		8. Date of Bir	H	County	Of Death	lace (State or Fore	ion
	Funeral Director		214-22-2282 Usual Residence of Decedent	1 M 2 G.F	85	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)	919		lace (State or Fore try) York	gn
	the Marylan 28a-f show offilied at	ector	MD Harford 10e. Street and Number		Fall	ston	10f. Zip	0-1-				10.00			0d. Inside City Limi	
9036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "naturel", or Items 23e or 28e-f show event, I'm Medical Expirition of the most be notified at	d by Funeral Director	1706 Arabian Wa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1Yes 2XV If Yes, Give Year or Dates:		1	21	047 lent of Hi		gin? (Spec i, Puerto R	ify Yes or No ican, etc.)	US	SA 14. Race	hat Coun - Americ k, White, e	an Indian, etc.	
21215-0036	filed within 72 h Hygiene. Ither than "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5- n/a		(Give	tent's Usua kind of wor DO NOT us	k done o	lurina most	t of working	g			siness/Ind	,	
Maryland	Mental Mental arked o	To Be	17. Father's Name (First, Middle, Last Donato LaPenna 19a. Informant's Name/Relationship			10h Mailia	Addross	(Street 5	Carm	ela L	First, Middle,	со			0.41	
Baltimore, Mai	es 1 and 2 and 2 of Health ar fitem 27 is r other trau		Ronald Mayr/Sor 20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 3	Removal from State	20b. Plac	170 e of Dispo etery, cren	6 Ara sition (Nam natory or ot	biar ne of ther place	Way	, Fal 9/2	Route Number Uston, te 9/05	MD 20c. Lo	210 cation - 0	47 City or To		
Baltin	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Special Service Lice) 21. Signature of Funeral Service Lice Michael I Fi		Gard	22	of Fa	Addres	s of Facility	oleum '	me of Timo		to., ney		ey, Inc.	
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tarry, learn a to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused	consequent bres.	nce of):	er the mode	a of dying	such as c	cardiac or	respiratory and	rrest,			Approximate Interval Between Onset and Death	3
P.O. Box 68760,	The law requires that the death certificate be executed te has been signed by the attending physician and orgen? should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions of	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal de ime of death	ath 3 h	Ectopic pre	ecify)	a ia Danil		OO- Dida		Mon		Day Year	
Vital Records,	law requires tas been signed a Should be considered	ompieted by	MTN	onthouning to dealth bu	THOU THE SUITE	ig in the tr	iderlying ca	use give	n in Рал I.		1 \(\) Y	res 2	24b. W	3 Proba	bly 4 Unknow y findings availab	le
Vital R	Physician: The this certificate har all director, page	BeC	25. Was case referred to medical examiner?	Hospital					_		performance 1 Test Yes Check only or	rmed? 2D No ne)	de 1 (eath?	2□ No	
of	ng Phys fter this neral dir	ertification; To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation		28	Outpatient b. Time of Injury		lc. Injury Work	4 Nur	28	5 ☐ Resid d. Describe h					
DIV	og afte	ai Certific	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	(Specify)						City or Tow	vn, State)			Route Number,	
	To the Hospitel within 24 hours a To the Funerel completely filled	Medica	(Check only 2 Medical Example) 29b. Signature and title of certifier	niner: On the basis of and manner state	examination	and/or inv	estigation,	in my op	inion, death	h occurred	at the time, o	date and	place, ar	ner as sta nd due to t (Month, D	the cause(s)	
)	4		30. Name and address person who	completed cause of do	ath (Itam 22	a) (Type 5	I	56	545			7	1	105	*	
	Sta	ite_	SHIWI KHOSG 31. Date filed (Month, Day, Year)	206 HA)	52 27	#10	2, 1	36L	- A 11	R,MI	210	14				
	Registr	- 0.0	SEP 2 9 ZUU	32. Registrar	St.	STORE	and the									

Anna M. Mayr

	٠		1 - For State of Maryland / D	Department of Health and N Certificate of Death		2005 31651
	Physic		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
,	/Medi Examii		William Russell Maxwell 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center		Septembe	r 25, 2005 04:55 M 4c. County of Death Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 1 M 2 F 83	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 15,	
	hours after death with the Maryland lurel', or Items 23e or 28a-f show al Exartifing Frust for notified at	Director	10a. State 10b. County 10c. City, Town Maryland Harford Bel A 10e. Street and Number		100	10d. Inside City Limits 1☆ Yes 2 □ No Citizen of What Country?
	be filed within 72 hours after death with ital Hygiene. Industrie the the there is do other them inclured; or liems 23e or event, the Madical Examinating the seent,	Funeral DI	138 Wallace Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21014 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		USA 14. Race - American Indian,
5-0036	hours afte	by	1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify: Decedent's Usual Occupation		Black, White, etc. Specify: White
C1212	d within 72 giene. er then "ne er the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work life. DO NOT use retired)	ring	Kind of Business/Industry S. Government
yland		To Be C	17. Father's Name (First, Middle, Last) William Rex Maxwell	18. Mother's Nam Janet	e (First, Middle, Maid Neoma Ru	en Sumame) 155 ell
re, Mar	1 and 2 Health a tem 27 Is		Gladys Maxwell / Wife 1 20a. Method of Disposition 20b. Place of	. Mailing Address (Street and Number or Rur .38 Wallace Street, B Disposition (Name of	el Air, Ma	
altimor	permit. Pages Department of Important: If it eny injury or o		1 3 Surface 2 Cremation 3 Premoval from State	ry, crematory or other place) r Memorial Grdns, 9- 22. Name and Address of Facility McComas Funeral Ho	29-05 Bcl	Air, Maryland
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	1317 Cokesbury Roa not enter the mode of dying, such as cardiac	d, Abingdo or respiratory arrest,	on, Maryl and 21009 Approximate Interval Between Onset and Death
	/Medical Examiner		540 10 (01 23 2 5511364461168 5)	1 day
V ,0070	cate be executed physician and the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate causs. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			
O. BOX 0	the death certifi y the attending ached for use as	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
colds, r	w requires that s been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
מו חפכ	ilcten: The law r certificate has be rector, page 2 sh	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
OII OF VITAI	nding Physicien: The tith. ': After this certificate his funeral director, page	ation; To Be	27. Manner Death 28a. Date of Injury 28b. Ti	tpatient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how inj	
S A	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	to the Hospitel or Al within 24 hours after or To the Funerel Direc completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	D/or investigation, in my opinion, death occurr	ed at the time, date ar	nd place, and due to the cause(s)
ı	with To 1	Σ	29b. Signature and title of certifier	Type, Print) No-Th Ave, B	29d. D. Se c	ate signed (Month, Day, Year) oten-ber 27, 2005
	10		30. Name and a ress of person who completed cause of death (Item 23a) (T. Kevin Lynch MD 2	Type, Print) No-TA Ave, B	'el Air, .	Md. 21014
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2005 32. R strar's Signature	Louis		

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F		Mental Hy		05 316	52
	Physici	an	1. Decedent's Name (First, Midd					2. Date of De	eath Day	Year 3. Time of D)eath
	/Medic Examir	cal	Rose (nmn) 4a. Facility Name (If not institution Bel Air Houth of	1 0		4b. City, Town, or	Location of Dear	15ept	4c. County	of Death	<u>~ "</u>
	Funeral Director		5. Social Security Number 164–10–2921		ge (In yrs. last birthday, 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	th ay, Year) 4, 1912	9. Birthplace (State or Country) New Jersey	Foreign 7
	within 72 hours after death with the Maryland one. one. than "natural", or Items 23a or 28a-f show the Marical Ever in etrinial be notified.	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Harfo 10e. Street and Number	15.	10c. City, Town or L Bel Air				10g. Citizen of	10d. Inside City 1 Nes 2	
	death with ms 23a or	Funeral Director	1600 Lynndale (12. Was Deceden	t Ever in U.S. 13.	21014 Was Decedent of H	ispanic Origin? (S	Specify Yes or No	USA - 14. Rac	ce - American Indian,	
900	ours after ral', or Ite	ρ	1 ☐ Never Married 2 ☐ Mai 3 🔀 Widowed 4 ☐ Divorce	If Yes, Give] No	If Yes, specify Cuba	sn, Mexican, Puer	to Rican, etc.)	Bla Specif	ck, White, etc. ^{y:} White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, if a Medical Eria', if at instit to rotifice and once.	Completed		nt's Education est grade completed) College (1-4or	(Give life.	dent's Usual Occup e kind of work done o DO NOT use retired	during most of wa ()	orking		usiness/Industry	e
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, II a.M.	To Be C	17. Father's Name (First, Middle, Ruggiero	Í	Samartino			me (First, Middle (unk	, Maiden Surnar		
	and 2 sho saith and I n 27 is ma		19a. Informant's Name/Relation Randie McConnel			ng Address (Street					
Baltimore,	Pages 1 and ment of Health ant: If item 27 ury or other tr		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other	3 Removal from State	20b. Place of Disp cemetery, cre		ee)	Date 29/05	20c. Location Bellmawi	City or Town, State	
Balt	permit. Pag Department Important: I any injury o once.		21. Sign tyre of Fun (fill legice	Licensee		2. Name and Addres	-			Home, P.A. aryland 2100	
	Physician /Medical Examiner	0	23a. Pan 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on each	ed the death. Do not en line. 6 C	ter the mode of dyin		c or respiratory a	rrest,	Approximate Interval Betwee Opset and De	ath
8760,	ate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Extra Unjury 17, 17, 18, 19, 19, 19, 19, 19, 19, 19, 19, 19, 19	С	s a consequence of): s a consequence of):						
P.O. Box 68	ath certific titending p or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy	**			te of delivery onth Day Ye	ear
	w requires that the de been signed by the a should be detached f	ed by Pi	Part II. Other significant condit	ons contributing to death	but not resulting in the t	underlying cause giv	en in Part I.	23e. Did t		tribute to the cause of dea 3 ☐ Probably 4 ☐Un	
Division of Vital Records,	iician: The law requ certificate has been rector, page 2 shoult	Completed						24a. Was auto perfo 1 Yes	psy ormed?	Were autopsy findings av prior to completion of cau death? 1Yes2 No	allable use of
f Vita	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 ☐ ER/Outpatie	nt 3 DOA	or:	ath <i>(Check only d</i> Home 5 ☐ Resi		er (Specify)	
ision o	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certification;	3 Suicide 6 □ Could	not be an Place of I	ay Year) 28b. Time of Injury	M 1 🗆	/ at <br Yes 2 □ No		how injury occur	red oer or Rural Route Numbe	0,
Div	pital or A	Certif	4 Homiciae	building, e	etc. (Specify)		and data and place	City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medica	(Check only 2 Medica one) 29b. Signature and title of certifications	Examiner: On the basis and manner s	of examination and/or initated.	vestigation, in my o	pinion, death occi	urred at the time,	date and place,	and due to the cause(s)	
	F 3 F 3		· pr	MS	death (la on) or	Disk	652		Spatimb	anner as stated. and due to the cause(s) d (Month, Day, Year) J G, 2003	-
	4		30. Name and a rress of person SCGA 31. Date filed (Month, Day, Year	who completed cause of	trar's Signature	enve B.	1 Air	Mary	lynd o	1014	
1	Sta Registi			9 2005	ins & M	pertu		,			

DHMH 17 Rev 1/2001

Asse Mcconnell

Raymond Thomas Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien20505-06477 31653 For State Registrar crn Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Miller Raymond Thomas September 9:56 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□ F Director June 4, 1953 | Connecticut 220-62-1837 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar mast be notified at 1 ☐ Yes 2 No <u>Mary</u>land Cecil Port Deposit Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21904 USA death 144 Harford View Drive Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Department of Health 5+ Addictions Counselor Ith and Mental Hygie 27 te marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Walter Duffy Miller Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a
Department of Health au
Important: If Item 27 te
any injury or other trau Carol N. Miller - Wife 144 Harford View Drive, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion U.M.C. Cem. 9/27/05 Bel Air, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple **Physician** disease or condition resulting in death) injuries /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine riate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Cher (specify) the o 9 Unknown 9 Unknown Division of Vital Records, P. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2□ No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cthen 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred operator of motorcycle that strack 1 Natural 5 Pending death. 1 ☐ Yes 2 No investigation 9-22-05 2 Accident
3 Suicide
4 Homicide 9:04 A fixed objects Director: 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) Dr. Jack Rd News within 24 hours after or To the Funeral Direct completely filled in by Road Harmony chapel prive, Port Deposite mid 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

LI LING 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Dey, Year) September 23, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 16, 2005 **Physician** 2:28 PM John Moss /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Liberty Heights Nursing Center If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days 1፟∑M 2□ F Yrs. Dec 7, 1930 Director 212-30-6203 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ty∑Yes 2 □ No Baltimore Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21215 4212 Penhurst Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. e filed within 72 hours efter of Hygiene.

I Hygiene.

other than "netural", or itel 1 [X]Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-0020 Specify: black Completed by 3 Widowed 4 Divorced Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 0 chef restaurants 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Pages 1 and 2 should be finent of Heelth and Mental Hint: if item 27 is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth an important: if item 27 is eny injury or other trau Lillie Moss/spouse 4212 Penhurst Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ♥ Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Signature of Funeral Service Licensee
Ronald S, Wade nuce Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CONGESTIVE /Medical Examiner Due to (or as a consequence of) CORONARY Examiner bunel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cerlifier 05 30. Name applied ress of person who completed cause of death (tem 23a) (Type

Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year) SEP 2

29

2005

545

Baltimore,

Division of Vital Records, P.O. Box 68760,

Andre Martinez 05-05786 NJM

ו כנ	00		110000	State of Maryland	/ Dens	ertmont of L	loolth and M	lontal Hyair	ne Legible	
			T = For State Registrar	State of Maryland	Cer	tificate of	neaith and iv Death		Z 0 0 5	31655
			Decedent's Name (First, Middle, Las	:t)			Journ	2. Date of Death		3. Time of Death
	Physici		Andre Martinez					Month August	28 200	
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
			3923 Norfolk Ave	enue		Baltim				
	Funeral		5. Social Security Number 6. Se	9x 7. Age (<i>in yrs. l</i> as ☑M 2□F 48	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day,)	(ear) 9. B	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	40	115.			UCL 17,	1930	unk
	yland Now		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mar	ctor	MD Baltime	ore Ra	ndall	stown				1 ☐ Yes 22K☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of Whal	
	within 72 hours after deeth with the Maryland ene. then "natural", or Items 23e or 28e-f show ta Medical Exercitar must be notified at	Completed by Funeral Director	30 Coachman Court		1.2	211			14.5	unk
	Item Item	-un-	11. Marital Status unk 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔯 No	13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - An Black, Wh	
920	urs af	by	3 □Widowed 4 □Divorced	If Yes, Give Year or Dates:	1	¥Yes 2□No	Specify: mex	ican	Specify:	white
<u>0</u>	72 ho	ted	15. Decedeni's Ed (Specify only highest grad		16a. Deced	lent's Usual Occup	eation during most of works	16	6b. Kind of Busines	s/Industry
2	ithin se.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d) Host of Work			
2	lled w tygier her ti		17. Father's Name (First, Middle, Last)	unk			10 Mark N	unk	···············	unk
Maryland 21215-0036	ntal h) Be	17. Father's Name (First, Wilddie, Last)			unk	18. Mother's Name	i (First, Middie, Mi	uden Sumame)	unk
چ	should nd Me mark mark	2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street	and Number or Rura	l Route Number, (City or Town, State	Zip Code)
Σ	nd 2		O.C.M.E.				eet Baltin			
Se,	of Head		20a. Method of Disposition		e of Disponetery, cren	sition (Name of natory or other place		ate 20	c. Location - City of	or Town, State
<u><u>E</u></u>	Page ment ant: fi ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Specify	in state						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show any Injury or other treumatic event, the Medical Examinat Examinat Be notified at ange.		21. Si matore of Funeral Service Licen:	Wade Datector		Name and Addre		655 พ	Raltimore	Ctroot
	2 □ E • Q		Service of the servic	1 // yell			omy Board			
			23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of Immediate Cause (Final	one cause on each line.	Do not ente	er the mode of dyin	ig, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. NARCOTIC AND		NOL INTO	XICATION			
	Examiner				nce oi):					
	7 -	Je	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):					
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
,092	Attending Physician: The law requires that the death certificate be executed rideath. sctor: Atter this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Ē	resulting in deathly cast	Due to (or as a consequer	nce of):					
387	physics the l	dicai		d.		_				
×	certif ding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc	y				23d. Date of d	eliven
ă	death e atter	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat		Ectopic pregnancy Other (specify)			Month	Day Year
P.O. Box 68	t the by the tache	Physician/Med	9 □Unknown	9□ Unknown						
S, F	res that the death certific igned by the attending p be detached for use as	by P	Part II. Other significant conditions co	intributing to death but not resulti	ng in the ur	derlying cause giv	en in Part I.		•	to the cause of death?
ord	w require been si should b	ted						1 🗆 Yes	2 520% 3 □ 8	Probably 4 Unknown
Division of Vital Records,	e faw i has b	Completed	COCAINE USE	1				24a. Was an autopsy	prior to	autopsy findings available completion of cause of
屈田	: The							performe 1 Pes 2		s 2 No
ĬĬ K	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		3 DOA Oth	26. Place of Death			
ŏ	tending Physician: The I Beath. tor: After this certificate ha the funeral director, page	2	Yes 2 □ No 27. Manner of Death	28a. Date of Injury 28	8b. Time of	28c. Injun	4 radialing floor	ne 5 ☐ Resideno 28d. Describe how	e 6XIOther (Sp	ecify) Scene
<u>o</u>	nding ath. r: Afte e fune	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) found 8-28-05	und at	M 1 🗆	k? Yes 2 ∦ ∫No	UNKNO	WN	
Vis	or Atten after deat Director: in by the	titic	3 ☐ Suicide XX Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			2	281. Location (Stre City or Town,	et and Number or F	Rural Route Number,
ā	ital or raft aft	Cer		FOUND IN A	DWELI			3923 NOR	FOLK AVE.	,BALTO.,MD
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exam	ysician: To the best of my knowle liner: On the basis of examination	edge, death n and/or inv	occurred at the tin	ne, date and place, a	and due to the cau	se(s) and manner a and place, and du	is stated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			. Date signed (Mor	
)	⊢≯≓ö		1/	1 /1-		OCME		į.	igust, 28	
			30. Name and address of person where	completed cause of death (Item 2	3a) (Type, I	Print)				
			N+144 C.	aff LSnD		111 Pe	nn Street	Baltimo	ore, Mary	land 21201
	Sta		31. Date liled (Month, Day, Year)	32 Registrar's Signatur	e And	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 5 per fh 8847 9-30-05 vt
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 23, 2005 **Physician** Margaret P. McNamara 11:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1119 Rosedale Avenue Rosedale Baltimore 8. Date of Birth (Month, Pay, Year) 6/26/1927 5. 5**220-20-15283** If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🕱 F 6/26/1927 Yrs 78 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked othar than "natural, or Itams 23a or 28a-f show 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 7 is marked othar than "natural", or Itams 23a or 28a-f show traumatic avant, Ita Medical Examinar mast be notified at MD Baltimore Rosedale 1 ☐ Yes 2 X No Director 10e. Street and Number t0f. Zip Code 10g. Citizen of What Country? 1119 Rosedale Avenue 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 Widowed 4 □ Divorced If Yes, Give Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Clerk King's Liquors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pietro Collini Edna Hartmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erin Phillips 6504 Golden Ring Road Rosedale, MD 21237 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages i Department of F Important: If ite any injury or otl once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 9/29/05 Baltimore ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Avenue Rosedale, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ERLEB ROVAS CUVAR Physician ACCIDENT (CVA) 21/05 disease or condition resulting in death) /Medical OBSTRUCTURE PULMUNARY MISERUCEPD 17Roma Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner 21/05 The law requires that the death certiticate be executed +41'ERTIENSIUN Due to (or as a consequence of): physician a the burial-1 Box 68760, attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by OSTEO ARTHRYIS Probably 4 Unknown 0 STEO PO RUSIS 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: P 1 ☐ Yes 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 - Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 🗌 Accident Diractor: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Vithin 24 hours after To the Funaral Dir certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -48025 Sohail Grw 30 Name and address of person who leted cause of death (Item 23a) (Type, Print) (WESACO AVE BATIMORE, UD 21237 ARMI, MD JOHN L 1224 31. Date filed (Month, Day, Year) State Registrar SEP 2 9 2005

			1 - For State Registrar	State of Marylar	nd / De	partme <i>ertifica</i>	ent of Ho ate of D	ealth a	and Mei	ntal Hygie	2005	31657
	Physici /Medio	cal	Decedent's Name (First, Middle, Last, TYLER DAYNE MA Facility Name (If not institution, give	JOR	_	4b Ci	ly, Town, or	Location		Date of Death Month	Day Yeer 2 2 05	
	Examir Funeral Director	ier	Franklin Squar 5. Social Security Number 6. Sec	e Hospito	L (Last birthd	ay) If Und	05C (der 1 Year	If Under Hours	2	Date of Birth (Month, Day, Y	Baltir	
6	n the Maryland r 28a-f ehow nylitied at	tor	10a. State 10b. County MD. BALTIMOR		ity, Town or	Location	LLE					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
Ma	th with	Funeral Director	10e. Street and Number 8222 BONAIR ROAD			10f. 2	Zip Code	212	34		Citizen of What Cou	,
10 Sc	hours after death i	۵	11. Marital Status 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	J.S. 1		pedent of His pecify Cuban 2 No	panic Ori , Mexican Specify:	igin? (Specify n, Puerto Ric	/ Yes or No- an, etc.)	14. Race - Amer Black, White Specify: WH:	
Brid 1215-0036	n 72 "na"	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(G	ive kind of t e. DO NOT	sual Occupativork done du use retired)	iring mos	t of working	16	b. Kind of Business/li NONE/II	,
$\mathcal{B}\mathcal{O}\mathcal{V}$ Maryland 2	Menta Menta arked aric ev	To Be C	17. Father's Name (First, Middle, Last) ROBERT MAJOR					18. Mothe		irst, Middle, Ma. DGEMAN		111111
	1 and 2 sho Health and Iem 27 is ma		19a. Informant's Name/Relationship (Ty ROBERT MAJOR/FATH	IER	822	22 BOI	NAIR R		BALTIM	ORE, MA	ity or Town, State, Zi RYLAND 212	
βaby	it. Page rtment o rtant: If njury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funer (February Education Section Sec	lemoval from State GAI	cemetery, c	OF FA	r other place VITH		Date 10/2/2 V CHAR	005 B	c. Location - City or T ALTIMORE , ZEILER & S	MARYLAND
8760, <	Physician /Medical Examiner	dical Examiner	23. Part1 Enter the disease, or complishow, or heart failure. List only or Imm chare Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the deather cause on each line. Due to (or as a consequence of the c	quence of):	enter the m	ode of dying,	such as		spiratory arrest	E, MARYLAN	ND 21224 Approximate Interval Between Onset and Death
P.O. Box 6	requires that the death certificate een signed by the attending phys hould be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il déath :	3 □Ectopic 5 □ Other (23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions con	1	Sior		cause giver	in Part I.		23e. Did tobac	co use contribute to t	the cause of death?
Division of Vital Records,	The law ate has b page 2 sl	e Completed	Respired to medical	Distress	5 5	Aug	rom	0		24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
of Vil	Physicia this cert ral direct	To B	examiner?		ER/Outpat	ient 3 [Other	4 □ Nur	rsing Home		e 6 ☐Other (Special	(y)
ision	Attending Physician: r death. sctor: After this certific. by the funeral director.	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	Injun	M		s 2 🗆 N	No	Describe how i		
Div	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Specify	y) wledge de	ath occurre	d at the time	, date and	d place, and	City or Town, S	(a) and manner as a	
	within 24 To the Fu completel	Medicai	(Check only one) 2 Medical Exemirate one) 29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	ition and/or	investigatio	en, in my opir 9c. License r	nion, deat	h occurred a	t the time, date	and place, and due to Date signed (Month,	o the cause(s)
	F ≯ F 8		Melinda	JElliol J.	Wo		D Ha		1	250.	9-22	2005
			Or. Melinda E.	Mott 900	OFF		n 590	ac	Drive	Baltin	nove MD	21237
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2005	32. Registrar's Signa	iture	a de la	,					

			For State Registrar	State of Man		artmen					Reg. No. U	05	3165	
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)						Date of Dea	Day	Year	3. Time of Dea	th) M
	/Medic	al-	Emmett Anderso			at Cit.	T	Location of	-4 Darath	eptemb		2005 Ity of Deatl	2:14 P	101
	Examin	er	4a. Facility Name (If not institution, given Doctor's Communi				nham	Location o	or Death	•			" George's	
16	Funeral		5. Social Security Number 6. S		n yrs. last birthday) If Under	r 1 Year	If Under		. Date of Birt	h	9. Birth	hplace (State or For	eign
- P	Funeral Director		224-22-2186	X M 2□F 9.	5 Yrs.	Months	Days	Hours	Min.	(Month, Da une 12	, 1910	Vir	ginia	
	pu >	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation						1	10d. Inside City Lin	mits
	ahov ehov	ō,			Mitchell								1 □ Yes 2 🛚	
	28a-i	Directo	Maryland Prince O	eorge s	MICCHEII	101. Zip	o Code				10g. Citizen o	of What Co	untry?	
	3a or		10501 Meadowridge	Lane		20	721				U.S.A	•		
	tiled within 72 hours atter death with the Maryland Hygiene. other then "natural", or itema 23a or 28a-f ehow ent, the Madical Evar, illerinast be notified a	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Dece	dent of Hi	spanic Orig	igin? (Speci	fy Yes or No		ace - Ame	ncan Indian, e, etc.	
92	or its	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give		1 Yes					Spec	cify:		
ģ	tural'	q pe	3 X Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a Dec	edent's Usu	al Occupa	ation			16b. Kind of		.ack Industry	
5	n na	Completed	(Specify only highest gra	ide completed)	(Giv	e kind of wo DO NOT u	ork done d	<i>luring</i> mosi	t of working	,			,	
212	yiene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Cu	stodi	an				Schoo	1 Sys	tem	
B	al Hyg	Be C	17. Father's Name (First, Middle, Last,								Maiden Sum	ame)		
Maryland 21215-0036	Ment Marked	ဥ	Edward Archer Ni				/=:		ie We		. 01	- 01-1-	T- 0- d-)	
Mar	12 sh h and 7 ie m traum	İ	19a. Informant's Name/Relationship (er, City or Tou		up Code)	
	1 and Health em 2: ther i		James Nicholas (20b. Place of Disp cemetery, cre				Da	te	20c. Locatio		Town, State	
nor	eges int of t: if it y or o		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Memoval from State	cemetery, cre Nicholas			J.	9/17	/05	Buck	ingha	m, VA	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or itema 23a or 28a-1 show any injury or other traumatic event, the Mudical Exactinational be notified at any injury or other traumatic event, the Mudical Exactinational be notified at another.		21. Signature of Funeral Service Lice			22 Name a	nd Addres	s of Facilit	tv	1				
ä	Depa Impo any i		Junain 12	Moreon		Reid P.O.	Box	inera 247,	HWY.	e 15, D	illwyn	, VA	23936	
\$			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not e								Approximate Interval Betweer Onset and Deat	
8760,	Attending Physician: The law requires that the death certificate be executed to death. Total and the certificate has been signed by the attending physicien and in position of the tuneral director, page 2 should be detached for use as the burial-transit and the tuneral director.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Congesti Due to (or as a complete to c	onsequence of):	Fail	ure							
.O. Box 6	it the death certifica by the attending pt tached for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of particles of the common of the com	Fetal death 3	□Ectopic p □ Other (s						Date of deli Month	ivery Day Year	
<u>α</u>	res that igned b	by PI	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying	cause give	en in Part I	l.	23e. Did t	obacco use co	ntribute to	the cause of death	?
rds	w require been sig should b		<u>Hypertensive</u> Ca:	rdiovascular	Disease					10	Yes 2□No	3 🗌 Pr	obably 4 XIUnkn	own
Records,	The law re ite has be bage 2 sho	Completed	Atrial Fibralat		Valve Di	sease				24a. Was autor perfo	rmed?	prior to death?	itopsy findings avail completion of cause 2 \(\sumber\) No	able ol
<u>ia</u>	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?	Beage				26. Place	e of Death (Check only o	nne)			
Ž <	Physic this ceral dire	2	1 ☐ Yes 2 X No	Hospital: 1 Inpatient	2 XER/Outpati			4 140			dence 6 🗆 0		cify)	
o uc	ding P. th.	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	or M	28c. Injun Worl	yat k? Yes 2 □		d. Describe i	how injury occ	urrea		
Division of Vital	i or Attend after death Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	OB Blood of Injunt				163 20		Bl. Location (: City or To		nber or Ru	ıral Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the best of r miner: On the basis of ex and manner stated	amination and/or	ath occurred	at the tin	ne, date ar pinion, dea	nd place, ar	d due to the	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of confine	n.o-		29	c. Licens				29d. Date sig	ned (Monti	h, Day, Year)	
)	1.			500			D48	213			Septem	ber 1	3, 2005	
	X		30. Name and address of person who				1	T	7. 11 -	MD 00	707			
			Neelaw Ashai, M 31. Date liled (Month, Day, Year)	.D. 4410	74th Av	re., I	ando	ver H	illls,	MD ZC	7/04			
	Sta Regist	ate rar	SEP 2 9 2005	132. Hegistial s	It for	de								

State of Maryland / Department of Health and Mental Hygiene 31659 Amend Item #10b-d Per Ana. Bd. G849 edificate of fleath Reg. No. 2. Date of Death **Physician** Normant Day Virginia /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Cherrywood are Reisterstown, MD Baltimore If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country), 8. **Funeral** 1□M 2☑F 3601 20 Director 55 unknoun Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or items 23a or 28a-f show any hiptor or any integration of the results of the profiled at any hiptory or other trannants event, the Medical Experiment must be notified at 10a. State 10c. City, Town or Location Baltimore 7 is marked other then "netural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Reisterstown 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral O OWN 0 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc, 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry unk unk Elementery/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Future Care Cherrywood 12020 Reisterstown Road Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 MOther (Specify) in state ^{22.} Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronald S Mikector Baltimore, MD 21201 Part 1. Enter the disease for combications heat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of) Physician/Medicai Examiner The law requires that the death certificate be executed ed by the attending physicien and deteched for use as the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence/of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by should be 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? peen (To the Hospital or Attending Physician: The law within 24 hours effer death.

To the Funeral Director: After this certificate hes! completely filled in by the funeral director, page 2: 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 20 No. Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Atvatural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Dey, Yeer) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Sieite 101 20, crossroads Tahoora Ka 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

2 9 2005

State of Maryland / Department of Health and Mental Hygien 2005 For State Registrar 31660 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 26^{Day} SEPT. 2005 NEWMAN **ESTELLE** 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 91 | Yrs. | Months | Days | Hours | Min. | 05/16/1914 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕻 F 213-10-7576 **Director** MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1**Y** Yes 2 □ No N/A BALTIMORE Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 7111 PARK HEIGHTS AVENUE APT. #205 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE by 3 Nidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES BRIDAL CONSULTING permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LIPNICK BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 SEAMOUNT ROAD - BEL AIR, MD 21015 MOLLIE J. SACHS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BETH JACOB CONG. 09/28/2005 FINKSBURG, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice see 23a. Part. Ent. the disease of mplications that shock, or leart failure. Ust only one cause on auceau 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between nset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) THEROSCHERONC COROBRO VASCULAR **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 3 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ KND EWAL DISEASE 1 □ Yes 2 □ No 3 Probably 4 Wknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2E No certificate 1 Yes 2 No 1 Tyes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: **♣** ■ Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lleun 28595 selle Name and address of person who completed cause of death (Item 23a) (Type, Print) PARK HELGIHIS 31. Date filed (Month, Day, Year) SEP 2 9 32 Registrar's Signature State Registrar

			1 - For Stete Registrar	State of Ma	ryland / Depa	artment of H			ene 2005	31661
	Physici	an	1. Decedent's Name (First, Middle, Las.					2. Date of Death Month		3. Time of Death
1	/Media	al	4a. Facility Name (If not institution, give	BRIEN		4. 67. 7		Septemb	er 23,200 ⁵	
	Examir	ier	Johns Hopkins Ba	,	ca1	Baltimo:	Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)
	Director		212-32-7400	^{™ 2} (СТР 60	Yrs.	Months Days	Hours Min.	June 9,1		1and
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation	<u>-</u>			10d. Inside City Limits
	Mary 9-f sh	to	Maryland N/A		Baltin	nore				XXYes 2□No
	or 28	Sirec	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
	s 23e	Funeral Director	4131 Falls Road				21211		USA	
10	ter de	Fune	11. Marital Status 1,□,Never Married 2□ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 21.X No	ver in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show alsea Exteringer must be maillised at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify: Whi	te
5-0	"netu	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupa	during most of work	cina	Sb. Kind of Business/	•
12	withir lene. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	00 NOT use retired, Attendant	,		Baltimore of Recrea	
br	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)		1 1001	Actendan		e (First, Middle, Ma	aiden Surname)	icion .
ylaı	ould b Menta arked arice	To	Edward M. O'Brien					Evelyn L		
Maryland 21215-0036	d 2 sh th and th and 7 is m treum	9	19a. Informant's Name/Relationship (T) Evelyn O'Brien	ype, Print) Mother					City or Town, State, 2 , Maryland	
<u>ə</u>	s 1 an f Heal item 2 other		20a. Method of Disposition	TIOCHET	20b. Place of Dispo	The state of the s		-	oc. Location - City or	
mo	Page nent o nnt: If ury or		1 🗓 Xurial 2 🗍 Cremation 3 🔲 I 1 4 □ Donation 5 □ Other (Specify,		ST. Mary			3/2005 Ba	altimore,	Marvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exercipes must be natified at once.		21. Signature / Funeral Service Licens	9° ()/	22 F	Name and Addres	s of Facility			
	σΩ <u>=</u> « α		23a. Part1. Enter the disease, or comp	liantians that assumed the	no doub Do out out	631 Falls	s Road, E	altimore,	Home,Inc. Maryland	
			shock, or heart failure. List only o	ne cause on each line	. Do not enti	er the mode of dying	g, such as cardiac	or respiratory arres	τ,	Approximate Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	aDue to (or as a	consequence of):					
В	Examiner	_	Sequentially list conditions.	b						
7	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsasse of Mary)	Due to (or as a	consequence of):				201	
×	execuin and ial-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760,	cate be executed obysician and the burial-transit	ical		d						
9	ertifica ding ph	Physician/Medical	IF FEMALE:	220 16 100 0160000 01						
Вох	death certific e attending pl d for use as t	clan	in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
0.	that the de led by the a detached t	hysi	1 Yes 2 No 9 Unknown	9□ Unknown		(0,000,00)				
s, P	es Ded	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause give	en in Part I.		cco use contribute to	
ord	w requir been si should	eted						1 🗆 Yes	2□No 3□Pro	bably 4 Unknown
Vital Records,	ne law has b ge 2 s	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
ta		e Co	25. Was case referred to medical				26 Place of Deat		No 1 ☐ Yes	20 MG
<u></u>	nysich nis cer I direct	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 🗌 Inpatient	2 ER/Outpatien	t 3 DOA Othe			ce 6 ☐Other (Spec	ify)
on of	Attending Physicien: r death. ector: After this certific. by the funeral director.		27. Manno of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	28c. Injury Work	?	28d. Describe how	injury occurred	
Division	or Attendatter death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injun	/ - At home, farm, stre		′es 2□No	28f Location (Stree	et and Number or Rui	ral Route Number
Ö	s after s after al Director	Certification:	4 Homicide	building, etc.	(Specify)	- 1, 12001y, 011100		City or Town, S	State)	arrosto vember,
	To the Hospitel or Attending Physicien: which 24 hours after deals are the Funerel Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1. Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e	xamination and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	se(s) and manner as	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner state	ru-	29c. License			. Date signed (Month	
}			Amimo			75	7727		9 27/05	
	h		30. Name and address of person who co	-	th (Item 23a) (Type, I			urdalk	0,000)
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's	X - WUN s Signature	mex 10	xue or	unable	- X1240	
	Registr		SEP 2 9 2005	Breeze ,	s Signature					

			1 ≃ For State Registrar	State of M	laryland /		artment rtificate					Reg. No	71115	3166	2
п	Physici	an	1. Decedent's Name (First, Midd	_		Dad.					2. Date of De Month	eath Da	25, 20	3. Time of Dea	
	/Media		Helen 4a. Facility Name (If not institution	Stewart		Рат	nter	Town or	Location o		Septemi		County of De		A ^M
1	Examir	ier	Lorien Nursing		,			umbi		Douin			Howard		
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last b	irthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Bir			lirthplace (State or Fo	oreign
	Director		578-52-1288	1□M 20 F	88	Yrs.	Months	Days	Hours	WIII.	8. Date of Bir (Month, Da Feb • 2	Ĭ, Î	917 1	Virginia	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation							10d. Inside City L	imits
	Mary -1 she	tor	MD How	ard	Colu	mbia	a							1 Tes 2	
	th the	Irec	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What		
	23e c	alD	6334 Cedar Lan	ie			2	21044	+			U	SA		
	72 hours after death with the Maryland "neturel", or Items 23e or 28s-1 show officel Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Deced If Yes, spec	lent of His	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No Rican, etc.))-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 🏿 Widowed 4 ☐ Divorce	If You Give X	No .		1 ☐ Yes 2	2⊠ No	Specify:				Specify:	White	
Maryland 21215-0036	2 hou	ted		nt's Education	168	a. Dece	dent's Usua	I Occupa	ition			16b. K	(ind of Busines		
215	d within 72 ho giene. Ir then "netur Ir e Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or	5+)	life.	kind of wor DO NOT us	e retired))	of workin	g	Woo	odward	& Lothrop	
121	e filed wi I Hygien other th		11			He	ad of				-		tore		
and	i be fi	Be	17. Father's Name (First, Middle, Bruce Franklir								(First, Middle,		n Surname)		
Z	2 should be and Mental Is marked o	2	19a. Informant's Name/Relations		19	b. Mailir	na Address	(Street a			enia Ro		or Town, State	Zin Code)	
Ma	s 1 and 2 should be filed f Health and Mental Hyg item 27 Is marked othe other traumatic event,		Rolen H. Paint								pe, VA		4479	, ZIP GOGE)	
Baltimore,	es 1 and 2 of Health of fitem 27 I		20a. Method of Disposition	0 FB	20b. Place o	of Dispo	sition (Nam	ne of ther place	9)	Da	ate	20c. L	ocation - City	or Town, State	
Ë	Pages ment of ant: If it ury or o		1 Burial 2 Cremation 14 Donation 5 Other (5		'		.ew Ce		1	9-28	3-05	St	trasbur	, VA	
3alt	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service	Licensee	00	22	. Name and Stove	d Address	s of Facility	í Hon	ne				
	70 = 0 0		23a. Part I. Enter the disease, o	r complications that cause	d the death . Se								rg, VA	22657 Approximate	
	Physician /Medical Examiner	9r	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einter Underlying	a	ine. E. Y. M. O. F. a consequence a consequence	VÍA oof):		, , ,						Interval Between Onset and Deat	th
68760, @	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	1 c	a consequence										
P.O. Box (that the death certificate ed by the attending phys detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deatl		Ectopic pre Other <i>(spe</i>						23d. Date of d Month	elivery Day Year	
	sign d be	by	Part II. Dther significant condition HYPERTE	noron				iuse give	n in Part I.				^	to the cause of death Probably 4 □Unkn	
eco	law as b 2 st	plet	CORONAF	LY ARTER	7 Pis	EA	-S E				24a. Was			autopsy findings avail completion of cause	
E B	Th ate pag	Completed	DEMEN	MITIA - Se	nile						perfo	rmed?	death?		OI .
∕ita	ysicien: The is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital:							Check on o				
Division of Vital Records,	ding Phys .r After this funeral di	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 1 No Pending	28a. Date of Inju		utpatien Time of Injury		Bc. Injury Work	r: 4X Nur at ? es 2 □ N	28	ie 5 ☐ Resid 8d. Describe h		6 □Other (Sp ry occurred	ecify)	
Divis	itel or Attenderins after deathrel Director:	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of In building, e	jury - At home, f tc. <i>(Specify)</i>					16	City or Tox	vn, State	9)	Rural Route Number,	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Aedical	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis of and manner st	of examination ar	e, death	estigation,	in my opi	inion, deatl	l place, ar h occurred	d at the time,	date and	d place, and du	ie to the cause(s)	
)	To To con	M	29b. Signature and title of certific	alles	<u>,</u>		29c.	D · 3	number 3046	9	S	29d. Da	te signed (Mor	th, Day, Year)	5
_	N		30. Name and address of person N B VELLANK;	who completed cause of a	death (Item 23a)	(Type,	Print) Jan	KUR	7:#	30	8, 00	lure	bia,	MD 2104	-5
Е	Sta Registr	ite	31. Date filed (Month, Day, Year, SEP 2	9 2005 32. Registi	rar's Signature	6	rank	,							

			1 - For State of Registrer	Maryland /		rtment of H			ene 2005	31663
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) Vincent Pap	san			٥	2. Date of Death Month	Day Yes 20 20	OST 7.32 PM
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number of Manyland 5. Social Security Number 6. Sex 7.	Hospit- Age (In yrs. last	birthday).	4b. City, Town, or Bar If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of D	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, To		cation		9-19-1	916	10d. Inside City Limits
	ith the Ma or 28a-f s	Director	Maryland N/A 10e. Street and Number	Bal	ltimo	10f. Zip Code	0.5	100	g. Citizen of What	1 ☑ Yes 2 ☐ No Country?
ပ္	after death w	Funeral Director	4146 Sixth Street 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Tyss 2	es?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	kmerican Indian, Vhite, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural; or Items 23e or 28e-f show or other traumatic avant, the Medical Evant are must be notified at	Completed by	3 X Widowed 4 □ Divorced Year or Dat 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4)	9S:	6a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired,	Specify: ation furing most of work)	ing 16	Specify: V	
and 212	ould be filed with Mental Hygiene. arked other than latic avant, the	Be	8th 17. Father's Name (First, Middle, Last) Joseph Papsa	0137)	Bus	Driver		e (First, Middle, Ma		
Maryland	ind 2 should be alth and Mental (27 is marked our traumatic ave	To	19a. Informant's Name/Relationship (Type, Print) Virginia Tate / Daughter			g Address <i>(Street a</i> Chelwynd		al Route Number, C altimore,	•	
Baltimore,	permit. Pages 1 and Department of Heal mportant: If item 2 and injury or other once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate ceme	etery, cren Have		e) ark 9/23	3/2005 G		ie, Maryland
Ba	Depar Impor any ir		23a. Part1. Enter the disease, or complications that call shock, or heart failure. Let only one cause on ear	#USAL used the death. I	4(001 Ritch	ie Highwa	y Balti	more, Ma	ice, P.A. ryland 21225
	Frrysician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death)		ice of):	heart			,	Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burlat-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	as a conseque	1000	wy_				
.O. Box 68	that the death certifice led by the attending ph detached for use as t	Physician/Med	in the past 12 months?	ome of pregnancy h 2 Fetal death at time of death m	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
S, P	equires that en signed by ould be deta	by	Part II. Other significant conditions contributing to dea	,	ng in the ur	nderlying cause give	en in Part I.			e to the cause of death? Probably 4 The Known
al Record	: The taw requirate has been page 2 shoul	Completed	Diabetes mell					24a. Was an autopsy performe 1 \(\text{Yes} \) 2 [prior	
Vital	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 In	national 2 1/2	/Outpatien	Othe		h (Check only one)		S-asife)
of	ding After fune	H	27. Manne of Death 28a. Date of		b. Time of Injury	28c. Injury Work	4 Mulsing Ho	me 5 🗌 Residen 28d. Describe how		ъреспу)
Division	tal or Attending s after death. al Diractor: After ed in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of	f Injury - At home g, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	is of examination or stated.	and/or inv	vestigation, in my op	oinion, death occur	red at the time, dat	te and place, and	due to the cause(s)
	with To	2	29b. Signature and title of certifier	Star		29c. License	05/- 24	290	d. Date signed (M	Onini, Day, Tear)
	4/		30. Name and address of person who completed cause Marcia Cort, MD Uni	of death (Item 23	Ba) (Type,	Print) anyland	- 22.5	outh Br	mo 212 cene Sta	onth, Day, Year) 20, 2005 1 Let Bellman
	Sta Regist		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	Spen				,	

			State of Maryland / Department of He 1- For State Registrer Certificate of D		ygiene	31665
I	Physici		1. Decedent's Name (First, Middle, Last) Annie Bell Quiller	2. Date of Month	Death Day Year	3. Time of Death
	/Medic Examir		A 40 MM AV AV AV AV AV AV AV AV AV AV AV AV AV	Location of Death	4c. County of Dea	8:45 A
	1 m		Adventist Washington Hospital Takoma I	Park If Under 24 Hrs. 8 Date of I	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. June		thplace (State or Foreign ountry) L.Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sho	tor	Maryland Montgomery Takoma Park			1 No 2 No
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 20809		10g. Citizen of What C	ountry?
	ns 23	erai	7525 Carroll Avenue 20809 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His		U. S. A.	erican Indian
36	be filed within 72 hours after death with the Maryland that Hygiene. ad othar than "natural", or liams 23a or 28a-f show avent, I're Medical Examiner must be notified at	by Fun	Armed Forces? If Yes, specify Cuban 1 Never Married 2 Married 1 2 No If Yes, Give 1 Yes 2 No	spanic Origin? (Specify Yes or in Mexican, Puerto Rican, etc.) Specify:	Specify:	te, etc.
21215-0036	2 hours atural', cal Ex	d pa	2 3 Wildowed 4 Divorced Year or Dates: 110	tion	B 16b. Kind of Business	lack
215	ithin 77	Completed	(Specify only highest grade completed) (Give kind of work done do life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	uring most of working		
d 21	filed w Hygier Sthar th	e Cor		rker 18. Mother's Name (First, Midd	Home M.	aker
Maryland	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic avent, It e M.	To Be	Imayailahlo	Unavailak		
lary	2 should he and he is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an	nd Number or Rural Route Num	nber, City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Is marked any injury or other traumatic av once.		Sara Pyles (Friend) 900 G St. N. 20a. Method of Disposition (Name of	Date	Apt. 524 20c. Location · City or	20002 Town, State
OE	Pages nent of int: If If		1 ⊠eurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) **Community or other place, Crematory or other place, Lincoln Mem	"	Suitland	
Baltimore,	ermit. lepartri nporta ny inju		21. Signature of Funeral Service Licensee 22. Name and Address	s of Facility Latney	's Funera	Home
	0.U = 6 0		23 TO THE DISEASE, OF COMPILE TIONS THAT CAUSED THE DEATH. Do not enter the mode of dying	rgia Avenue,	N. W. Was	Sh.D.C.2001
	Physician		shock, of heart failure. List only one cause on each line.	line	411001,	Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):			3 Weeks
	LXammer	er	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			3 heels
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			3 weeks
760,	ate be executed hysician and the burial-transit					
687	tificate ig physi as the b	edica	d			
Box	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de	
0	at the dea by the al	ysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown		Month	Day Year
۵.	res that igned by be deta	by Ph		n in Part I. 23e. Dic	d tobacco use contribute to	the cause of death?
ord	v require been sig should b			1]Yes 2.102No 3.∏Pi	robably 4 Unknown
Records,	The law sate has b page 2 sl	Completed				utopsy findings available completion of cause of
Vital		a)	25. Was case referred to medical		2 No 1 ☐ Yes	2□ No
> >	Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Nopatient 2 ER/Outpatient 3 DOA Other	4 ☐ Nursing Home 5 ☐ Re		cify)
ono	ding P h. After t	tion:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 28b. Time of 28c. Injury 28c. Injury 38c. Injury	at 28d. Describe ? es 2 □ No	how injury occurred	
Division of	for Attan after deatl Diractor: In by the	Certification:	2 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)	28f. Location	(Street and Number or Ri	ural Route Number,
۵	Hospital or Attanding Physician: 24 hours after death. Funaral Diractor: After this certificately filled in by the funeral director.					
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	 date and place, and due to the nion, death occurred at the time 	e cause(s) and manner as e, date and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License	1.00	29d. Date signed (Mont	
			Marin D18	895	Seplembe	23, 2005
	(1)		Mobarum TD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mobarum TD D 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mobarum TD O 18	Sut 340, T.	AKOMA PARK	MD 20912
:-	Sta Registr		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature			
	91011	10 3	THE STATE OF THE PARTY OF THE P			

			T = For State Registrar	State of M	Maryland	d / Depa <i>Ce</i> a	artment of H	lealth ar D <i>eath</i>	nd Mental F	lygien Reg. No		31666
	Dhysia	ion	1. Decedent's Name (First, Middle,	Last)					2. Date of			3. Time of Death
	Physic /Medi			RAGIN					SEPIE!	n BER	20,20	18:47 M
7	Exami	ner	4a. Facility Name (If not institution,		0. 141	1	4b. City, Town, or	Location of E	Death	40	County of De	
	Funeral	۳		, , ,	ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8 Date of	Birth		A Birthplace (State or Foreign
	Director		248.52.6264	1□M 2 M F	70	Yrs.	Months Days	Hours	Min. 8. Date of (Month)	Day Year	4	Birthplace (State or Foreign Country)
	and		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	ecation				-	
	Manyl.	lo.	MD N/A			1more						10d. Inside City Limits 1 Yes 2 No
	r 28e	Director	10e. Street and Number		ORLI	HIVE	10f. Zip Code			10g. Ci	tizen of What	
	th with	al D	135 S. MONASTE	RY AVENU	E		212	29			usA	
	er dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ar Black, Wi	merican Indian,
36	irs afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 🔀 If Yes, Give Year or Dates:			1 ☐ Yes 2 🕻 No	Specify:	,,		2	
21215-0036	72 hours after death with the Maryland netural', or Items 23e or 28e-f show disel Examiner must be redified at		15. Decedent's	Education	· 	16a. Deced	dent's Usual Occupa	ation		16b. K	(ind of Busines	LACK
218	within 7 ene. than "r	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	life.	NOT use retired	fu <i>ring m</i> ost of)	working			
	filed w Hygier other th		10 TH GRADE 17. Father's Name (First, Middle, L.	NA		HOM	EMAKER				DOMES1	TIC
Maryland	8 E 5 8	o Be	BURNIE HODGE	151)				_	MAE M		,	
ary	should Ind Meni	To	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a					Zin Code)
	tand 2 Health a tem 27 ls		EDDIE RAGIN	(HUSBAND))		. MONAS	_	AVE. BA			21229
Baltimore,	ges 1 of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	Bemoval from State		ce of Dispo	sition (Name of natory or other place		Date	_	ocation - City o	
ţ	it. Pages ertment of l ortent: If it njury or o		`4 □ Donation 5 □ Other (Spe	ecify)			PARK	09	.26.05	BAL	JO. MI	D
Bai	permit. Pages 1 a Department of Hee Importent: If item any njury or otha		21. Signature of Funeral Service Li	censes		VA 51	Name and Addres NGHN C. C 51 BALTO, N	S of Facility APEENE	FUNERAL RE BALT	SER	2VICES 21229	
П			23a. Part1. Exter he disease, or c shock, or heart failure. List of	omplications that cause by one cause on each l	d the death. line.	Do not ente	er the mode of dying	, such as car	diac or respiratory	arrest,	760	Approximate Interval Between
	Physician	ů i	Immediate Cause (Final disease or condition resulting in death)	-a. Acuta	Myc	cende	ol Inta	chier				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a conseque	ence of):	el Infa		0			1212
		e	Sequentially list conditions, if any leading to immediate	b. Due to (or as	science	e Cov	anay A	teg	Visegge			10 years
/	cuted id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
, 0,	e exerian ar		resulting in death) Last	Due to (or as	a conseque	ence of):						
68760,	ificate be executed g physician and as the burial-transit	edical		d								
9 xc			IF FEMALE:	23c. If yes, outcome	of pregnance	ev						en a
Box	The law requires that the death cert lite has been signed by the attendin page 2 should be detached for use.	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ■ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Year
P.O.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown			, ,					
S, I	ulres tha signed d be del	by P	Part II. Other significant condition	s contributing to death b	out not resulti	ing in the un	derlying cause give	n in Part I.				to the cause of death?
ord	w require been si should b	eted	chore Res	Lagare	rereng				_ 1	Yes 2[□No 3□F	robably 4 Unknown
3ec	has b	Completed by							24a. Wa aut	opsy	prior to	utopsy findings available completion of cause of
a		e Co	25. Was case referred to medical						1 ☐ Yes	drmed? 2X No	death? 1 ☐ Ye	s 2□No
Division of Vital Records,	Physician: r this certificaral director,	To Be	examiner?	Hospital:	ent 2 FF	R/Outpatient	Otha		Death (Check only g Home 5 \ Res			w.
0 0	ng Ph ter th		27. Manner of Death	28a. Date of Inju (Month, Da	iry 2	8b. Time of Injury	28c. Injury		28d. Describe			ecity)
Sio	tendin eath. tor: Al	catic	Accident investigat	ion	,,,,,,			es 2□No				
<u>S</u>	Jor At after d Diract Jin by	Certification:	3 Suicide 6 Could not 4 Homicide determine		iury - At homic. (Specify)	e, farm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	d Number or R)	Rural Route Number,
_	spital		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	adae death	accurred at the time	deto and de				
	To the Hospital or Attending Physician: within 24 houss after death with 24 houss after death. You the Funeral Disactor: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Ex	aminer: On the basis o and manner st	ii examinatioi	n and/or inve	estigation, in my opi	nion, death or	ccurred at the time	, date and	place, and du	s stated. e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date	e signed (Mon	th, Day, Year)
	^			- MD			30584	8998		Septe.	use)	20, 2005
	/b		30. Name and address of person who Robe A Green Lel	o completed cause of d	leath (Item 2:	3a) (Type, P	rint) 54	Aga	u Ctos	pete 1	,	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi r in	ar's Signatur	9	ace, 3511	m-15,-6	رسی د	1629	1	
	Registra	190	31. Date filed (Month, Day, Year) SEP 2	9 2005	apples 1	& A	borle					

RAGIN, ANNIE

			For State Registrar	State	of Marylar	-	artmen rtificate					giene Reg. Noi	2000	5 3	31667
	Physici		Decedent's Name (First, Middle, ELLA	Last)	REAVES						2. Date of Dea	Day	21 200	r _	Time of Death
}	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City,	Town, or	Location of		septem		County of De	ath	<u> </u>
	Funeral		7-011 -	KIVER'	7. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Birt	th Vasal	9. B	FOR	(State or Foreign
	Director		183-16-7963 Usual Residence of Decedent	1□M 2፟ØF	91	Yrs.	Months	Days	Hours	Min.	(Month, Day JULY 2	8 19	14	Co <i>untry)</i> MARY	LAND
	Aaryland f show	or	10a. State 10b. County		10c. Ci	ty, Town or Lo		·MODI	7						nside City Limits
	ith the P or 28e-	Director	MARYLAND N/A 10e. Street and Number				BALTI 10f. Zip					10g. Citi	izen of What (Country?	
	oma 23e	Funeral [2807 HILLDAI		edent Ever in U	I.S. 13.	Was Deced	212 lent of Hi		gin? (Spe	ecify Yes or No- Rican, etc.)		I.S.A. 14. Race - An Black, Wh		ndian,
9036	ours after	by	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced		2∭XNo ive		1 ☐ Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Specify: BL		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23e or 28e-f show aumatic event, It e Modeal Executer must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College ((Give	dent's Usua kind of wor DO NOT us	k done o	lurina most	t of worki	ing	16b. Ki	nd of Busines	ss/Industr	у
d 21	filed w Hygien other th	Be Cor	7th grade 17. Father's Name (First, Middle, L	ast)		DOM	MESTIC		18. Mothe	r's Name	(First, Middle,		Sumame)		
ylan	should be and Mental is marked o	To B	JAMES E WHIT					1		A GI					
	りまいせ		19a. Informant's Name/Relationshi Annette Waters/1								<i>i Route Numbe</i> altimor				
ltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specific Processing		State	Place of Dispo cemetery, crei LLING (matory or or	ther plac)ate		cation - City o		State NSYLVANI
Baltir	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Fune II Service Li		KOI	WN	Name and C BF	d Addres	s of Facilit	UNIT	Y FUNER	AL H	IOME-HA	RFOR	D, P.A.
			23d. Part1. Enter the disease, or o shock, or heart failure. List	niv one cause on	each line.	th. Do not ent	er the mode	e of dyin	g, such as		BLVD, A		EEN, M	App	oroximate rval Between set and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Jue to	(dr as a consec	quence of):	rta	nc h	05					Olis	oct and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a consec	esper	jan							4	ear
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to	(or as a consec	quence of):									
O. Box 6	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregni birth 2 Feta nant at time of c nown	al death 3[Ectopic pro					2	23d. Date of d Month	elivery Day	Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant condition	as contributing to a	leath but not res	sulting in the u	nderlying ca	ause give	en in Part I.			bacco u es 2[se contribute	to the cau	use of death?
Records,	The law require ate has been si page 2 should b	Completed									24a. Was a autop perfor	sy	death	autopsy fi completi	indings available ion of cause of
Vita	Physicien: The la this certificate has ral director, page 2	o Be (25. Was case referred to medical examiner?	Hospital:				Othe)C		(Check only or	ne)			
Division of Vital	ding Phys h. After this funeral di	!	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	28a. Date (Mor		28b. Time of Injury		Bc. Injury Work	4/40	2	ne 5 Resid 28d. Describe h			ecify)	
Divisi	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot bo	e of Injury - At h ling, etc. <i>(Specil</i>	ome, farm, str fy)					28f. Location (S City or Tow			Rural Rou	ite Number,
	ie Hospite 24 hours ie Funera	Medical C	29a. Certifier (Check only one) Certifying	Physician: To the xaminer: On the b and mar	e best of my kno pasis of examina oner stated.	owledge, deatl ation and/or in	n occurred a vestigation,	at the tim	e, date and pinion, deat	d place, a	and due to the dead at the time, o	ause(s) date and	and manner a place, and du	as stated. ue to the c	cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	Muc	U M	N	29c	License	number	5	2	29d. Date	e signed (Mor	nth, Day,	Year)
	2		30. Name and address of person w	tho completed cau	se of death (Iter	n 23a) (Type,	Print) MN.	2	1014			1/	V		
	Sta Registr		31. Date filed (Month, Day, Yeer) SEP 2. G		Registrar's Signa	ature	2000								

			For State Registrar	State of Ma	•		rtment of H		and Me	ental Hy	giene	1115	31668
	9 4		Decedent's Name (First, Middle, Last	st)					1	2. Date of De	ath		3. Time of Death
Н	Physici /Medic		GLADYS &	MEY					<	Month EPTEM	BER.	26 200	20716 M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	Location o				County of Dear	th
		×	UMMS				BAL	Timo		, MD)	N/A	
	- Funeral Director		5. Social Security Number 6. S 215-30-4439	ex 7. Age	(In yrs. last birti	rs.	Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da DEC • 3	iy, Year)	Co	thplace (State or Foreign ountry) ARYLAND
	pu k		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Loca	ation						10d. Inside City Limits
	fanyla e ho	5			_00								1XXYes 2 ☐ No
	28a-1	Director	MARYLAND N/A 10e. Street and Number		DA.	P.T.T.	10RE				10g. Citiz	zen of What Co	ountry?
	3a or		2365 MCCULLOH S	TREET			212	17			U	.S.A.	
	death	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba		gin? (Spec	cify Yes or No)-	14. Race - Ame Black, Whit	
9	within 72 hours after death with the Maryland ene. than "naturel", or Itame 23e or 28e-f ehow then "naturel" or Itame and the nutified at the Maryland and the nutified at the Maryland and the nutified at the Maryland and the nutified at the Maryland and the nutified at the Maryland and the nutified at the Maryland and the Maryl	/Fu	1 Never Married 2 Married	1 Yes 2 N	lo		Yes 2X No	Specify:	, 1 4011011	noari, otc.,		Specific	
8	urel',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	100	Daniel	atta University	*****			165 V:	BI	ACK
7	n 72 n	lete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give k	ent's Usual Occup ind of work done O NOT use retired	durina mosi	t of workin	g	100. KI	nd of Business	industry
21215-0036	iene. Ithen	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5		COOF	RDINATOR					JOSEPH	HOUSE
D	Hyg other	0	17. Father's Name (First, Middle, Last)	1				18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)	
<u> a</u>	uld be Aenta rrked tic ev	To B	JAMES LEIGHTON					L.	ILLIA	N HARF	IS		
an	sho and h	. 10	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing	Address (Street	and Numbe	or or Rural	Route Numb	er, City or	Town, State, a	Zip Code)
Σ.	and and m 27 m 27		Delores A Queen/D	aughter			McCullo	n St.					
Baltimore, Maryland	ges 1 t of H H ite		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemetery	y, crema	ition (Name of atory or other plac			elte		cation - City or	
Ë	t. Pa rtmen rtant;		4 Donation 5 Other (Specification of Specification of Spe	-	GARRIS				10-05				S, MARYLAND
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or Itame 23a or 28a-f show any Injury or other treumatic event, Ita Modical Examinar must be multiled at once.		21. Signature of Funeral/Service Lines	1			Name and Addre LLIAM C 06 W NOR'			UNITY	FUNE	RAL HOM	IE P.A.
			23d. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do n	ot enter	r the mode of dyir	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. Mes	ENTE	RIC	- ISC	HEL	MA				Onset and Death
	/Medical Examiner		resulting in death)	•	a consequence o	•	()		0	<u>م</u>	_		
		PL	Sequentially list conditions, if any, leading to immediate		a consequence of		ASCUL	HZ 1	HECU	N34			
$\sqrt{}$	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	REN	JAL F	114	LIPE						
Ć.	icate be executed physicien and s the burial-transit	Еха	resulting in death) Last		a consequence o		~~~					-	
8760,	ite be iysicie iud er	dlcal	(d									
9	ntifica ng ph	0	IF FEMALE:										
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy				2	23d. Date of del Month	very Day Year
-	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death	5	Other (specify)						
0	that the	Ph	Part II. Other significant conditions of	contributing to death be	ut not resulting in	the und	dertying cause giv	en in Part I.		23e. Did	obacco u	se contribute to	the cause of death?
ds,	uires tha signed Id be de									10	Yes 2	No 3□Pr	robably 4 DUnknown
00	w require been si should l	Completed						,		24a. Was		24b. Were au	itopsy findings available
Re	ticien; The lav certificete has rector, page 2	ошь								auto perfe	psy ormed? 2 No	prior to death? 1 ☐ Yes	completion of cause of
ita	rtifice	Be C	25. Was case reterred to medical					26. Place	of Death	(Check only			
†	Physicien; r this certific ral director,	ToE	examiner? 1 ☐ Yes 2 ☐ 10	Hospital:	nt 2 ER/Out	patient	3□ DOA Oth	er: 4 □ Nu	rsing Hom	e 5□Res	dence 6	Other (Spe	city)
0	ng Pt fter th		27. Manner of Death 1 Deatural 5 Pending	28a. Date of Injur (Month, Day		ime of njury	28c. Injur Wor	k?		8d. Describe	how injury	y occurred	
sio	death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not b		• • • • •			Yes 2 🔲		04 1	C1-2212		al Barta North
Division of Vital Records,	al or At after d i Direct d in by	Certification:	4 Homicide determined		ury - At nome, fai c. (Specify)	rm, stre	et, factory, office		2	City or To			ural Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exer	nysician: To the best on the basis of and manner sta	examination and	, death d/or inve	occurred at the tire estigation, in my o	ne, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c. Licens		. 1		29d. Date	e signed (Mont	h, Day, Year)
			m	S	1		M	676	14		Sep	tember	26,2005
	5		30. Name and address of person who	0(5) 201	2 0 60	Туре, Р	NEST.	BA	5411	more	3, 1	W 2	26,2005
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 9 201	32: Registra	ar's Signature	Grace	S. D						
				10-10-10-1	5.00	Marine .							

neodore Robb -06543 M

> Physician /Medical Examiner

, Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23a or 28s-f show eny Injury or other traumatic event, Ira Modical Examinar must be mutified at once.

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. To the Hospitel or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	Registrar 1. Decedent's Name					Certificate of		2. Date of Dea	th Day_	Year_	3. Time of Dea
		DRE ROI						Septembe		2005	1510
ľ	4a. Facility Name (/			number)		4b. City, Town,	or Location of Dea	ith		y of Death	
	4939 We 5. Social Security N		s Road 6. Sex	7. Age (In	yrs. last birtho	Baltimo	r If Under 24 Hr)	9. Birthp	place (State or Fo.
	213-34- Usual Residence of	-7087	1 ∑ M 2□ F	66	5 Yr	s. Months Days	s Hours Mir	01/15		MAR	RYLAND
	10a. State	10b. County		10	c. City, Town o	or Location				1	10d. Inside City Li
	MD	N/Z	A		BALT	IMORE CI	TY				XXYes 2
	10e. Street and Nu	mber				10f. Zip Code		1	10g. Citizen of	What Cour	ntry?
-		VEST H	ILLS RO	OAD ecedent Ever	rin IIS	212		Specify Yes or No-	USA 14. Ba	ce - Americ	can Indian.
	 Marital Status Never Marr 	ied 2□ Marne	Armed	Forces?	1111 0.3.	If Yes, specify Cu	ban, Mexican, Pue	rto Rican, etc.)		ack, White,	
	3 Widowed	4X Divorced	Year or	s 2 🗍 No Give r Dates:	162 D	1 ☐ Yes 2 💢 No		}	Speci	ity: BLA	
			t grade complete		1 (0	Give kind of work don- ife. DO NOT use retir	e during most of we	orking	TOD. KING OF E	Juaii 1633/1111	uustry
-	Elementary/Second	ondary (0-12)	College	e (1-4or5+)		US DRIVE	•	1	MASS 1	rans	SIT
1	17. Father's Name	(First, Middle, L	ast)				18. Mother's Na	ame (First, Middle,	Maiden Suma	me)	
	GEORGE	E ROBI	3				ROSE	TAYLOR			
	19a. Informant's N	ame/Relationsh	ip (Type, Print)		19b. A	Mailing Address (Street	et and Number or F	Rural Route Number	r, City or Towr	n, State, Zip	Code)
L	THEODOF	RE A. I	ROBB JE		ON 45	09 REBEK	KA_CIR,	OWINGS Date	MILIS 20c. Location	MD_	21117
	20a. Method of Dis		3 □Removal fro		cemetery,	esposition (Name of crematory or other pl	lace)				
1		5 Other (Sp		Jiii Ciato	ARBUT	US MEM.		/04/05 1			
	21. Signature of	Pieral Service L	icensee	X	wen			OWELL FI			
T	23a. Part. Enter I	the disease, or	complications tha	at caused the	death. Do no		design and the second		ract		Approximate
	1 /			n each line.		t enter the mode of dy	ying, such as cardii	ac or respiratory arr	63 (,		Interval Between
	Immediate Cause	(Final	only one cause o	n each line.							Interval Between Onset and Deat
	disease or condition resulting in death)	(Final	- Hyp	ertensio	ie ather	oscleratic					Interval Between
	disease or condition	(Final	- Hyp	ertensio		oscleratic					Interval Between
	disease or condition resulting in death) Sequentially list confirm any, leading to in	(Final on onditions, on onditions, on onditions, on one of the one	a. Hypo	to (or as a co	ie ather	oscleratic					Interval Between
	disease or condition resulting in death) Sequentially list confirm any, leading to incause. Enter Undeate Cause (Disease or	(Final on on on on on on on on on on on on on	a. Hypo	to (or as a co	onsequence of	oscleratic					Interval Between
	disease or condition resulting in death) Sequentially list confirm any, leading to in	(Final on onditions, onditions, one of the original of the original of the original	b. Due	to (or as a co	onsequence of	oscleratic					Interval Between
	disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Undo Cause (Disease or that initiated event	(Final on onditions, onditions, one of the original of the original of the original	b. Due	to (or as a co	onsequence of)	oscleratic				R .	Interval Between
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death)	(Final on onditions, onditions, one of the original of the original of the original	b. Due	to (or as a co	onsequence of)	oscleratic					Interval Between
	disease or condition resulting in death) Sequentially list confidence in the cause. Enter Undercause (Disease on that initiated event resulting in death) IF FEMALE: 23b. Was deceder	(Final on on other or	a. Hyp. Bue b. Due c. Due d. 23c. If yes,	to (or as a co	onsequence of) onsequence of) onsequence of)	oscleratic	Cardiova		dislin	ate of delive	Interval Between
	disease or condition resulting in death) Sequentially list confidence in the past 12 light sequence in the past 12 light sequ	(Final on onditions, namediate entying injury stast	a. Hype Due c. Due d. 23c. If yes, 1 Liv 4 Pro	to (or as a co	onsequence of on	oscleratic	Cardioval		dislin		Interval Between
	disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	(Final on onditions, mediate artying injury s Last months?	a. Hyp. Bue b. Due c. Due d. 23c. If yes, 1 Liv 4 Pri 9 Un	to (or as a control or as a co	onsequence of on	3 Ectopic pregnan	Cardioval	scular o	23d. D.	ate of delive	onset and Deat
	disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	(Final on onditions, mediate artying injury s Last months?	a. Hyp. Bue b. Due c. Due d. 23c. If yes, 1 Liv 4 Pri 9 Un	to (or as a control or as a co	onsequence of on	sclentic	Cardioval	23e. Did to	23d. D. M	ate of delive	ery Day Year the cause of death
	disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	(Final on onditions, mediate artying injury s Last months?	a. Hyp. Bue b. Due c. Due d. 23c. If yes, 1 Liv 4 Pri 9 Un	to (or as a control or as a co	onsequence of on	3 Ectopic pregnan	Cardioval	23e. Did to	23d. D. M	ate of deliver	ery Day Year he cause of death
	disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	(Final on onditions, mediate artying injury s Last months?	a. Hyp. Bue b. Due c. Due d. 23c. If yes, 1 Liv 4 Pri 9 Un	to (or as a control or as a co	onsequence of on	3 Ectopic pregnan	Cardioval	23e. Did to	23d. D. M. Dibacco use converse 2 No	ate of deliver	ery Day Year the cause of death
	disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	(Final on onditions, mediate artying injury s Last months?	a. Hyp. Bue b. Due c. Due d. 23c. If yes, 1 Liv 4 Pri 9 Un	to (or as a control or as a co	onsequence of on	3 Ectopic pregnan	Cardioval	23e. Did to	23d. D. Months accounts an analysis with the state of the	ate of deliver	eny Day Year Dably 4 AUnkr
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause, (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on onditions, namediate erlying injury s Last nt pregnant 2 months?	a. Hype Bue b. Due c. Due d. 23c. If yes, 1 Liv 4 Progue uns contributing to	to (or as a control or as a co	onsequence of on	3 Dectopic pregnan 5 Other (specify)	CardioVIV.	23e. Did to 1 Y 24a. Was a autop: perfor 1 Yes eath (Check only of	23d. D. Molbacco use corres 2 \(\text{No} \) No an sy ymed? 2 \(\text{No} \) No (ne)	ate of delivers	eny Day Year Dably 4 AUnkr posy findings avai impletion of cause
	disease or condition resulting in death) Sequentially list confidence in the past 12 1	(Final on onditions, mediate arriving injury s Last months?	a. Hypotherical and the second	to (or as a control to (or	onsequence of onsequence of onsequence of onsequence of onsequence of onsequence of oregnancy regnancy of death of resulting in the office of the office of the office of the office office of the office off	3 Ectopic pregnan 5 Other (specify) he underlying cause s	CardioVIV.	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes eath (Check only or	23d. D. M. Spacco use corres 2 \(\text{No.} \) No an sy med? 2 \(\text{No.} \) No ence 6 \(\text{ZOIO} \)	ate of deliver lonth ate of deliver lonth Tribute to the state of th	eny Day Year Dably 4 AUnkr posy findings avai impletion of cause
	disease or condition resulting in death) Sequentially list confidence in the past 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 12 and 13 and 14 and 15	(Final on onditions, mediate errlying injury s Last on the pregnant of months?	a. Hype Due b. Due c. Due d. 23c. If yes, 10 Living to 10	to (or as a control or as a co	onsequence of onsequence of onsequence of onsequence of onsequence of onsequence of oregnancy regnancy of death of resulting in the office of the office of the office of the office office of the office off	3 Ectopic pregnan 5 Other (specify) he underlying cause general cau	CardioVM given in Part I. 26. Place of Dicther: 4 \(\triangle \text{Nursing} \) ury at ork?	23e. Did to 1 Y 24a. Was a autop: perfor 1 Yes eath (Check only of	23d. D. M. Spacco use corres 2 \(\text{No.} \) No an sy med? 2 \(\text{No.} \) No ence 6 \(\text{ZOIO} \)	ate of deliver lonth ate of deliver lonth Tribute to the state of th	eny Day Year Dably 4 AUnkr posy findings avai impletion of cause
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause, (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on onditions, mediate errlying injury s Last on the pregnant of months? No on one of the months? No on one of the months	a. Hypotherical and the second and t	to (or as a control outcome of pre-birth 2	onsequence of on	3 DEctopic pregnant 5 Other (specify) the underlying cause of the underlying	CardioVM 26. Place of Dither: 4 Nursing ury at lork?	23e. Did to 1 Y 24a. Was a autop: perfor 1 Yes eath (Check only or Home 5 Resid	23d. D. Mondan 24b. 24b. 22 No ow injury occur	ate of delivers and the state of delivers. Were autoprior to condeath? 1 X Yes	eny Day Year Day Year Dably 4 Munkr Dably 4 Munkr Daysy findings avain mpletion of cause
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Under Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 1 Yes 2 9 Unknown Part II. Other signification of the past 12 1 1 Yes 2 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Yes	(Final on onditions, mediate errlying injury s Last on the pregnant of months?	a. Hypotalia and the property of the property	to (or as a control outcome of pre-birth 2	onsequence of on	3 Ectopic pregnan 5 Other (specify) he underlying cause general cau	CardioVM 26. Place of Dither: 4 Nursing ury at lork?	23e. Did to 1 Y 24a. Was a autop: perfor 1 Yes eath (Check only or Home 5 Resid	23d. D. M. Dibacco use consess 2 \(\text{No} \) No an sy med? 2 \(\text{No} \) No injury occurrence 6 \(\text{XOT} \) Ow injury occurrence and Num.	ate of delivers and the state of delivers. Were autoprior to condeath? 1 X Yes	eny Day Year Dably 4 AUnkr posy findings avai impletion of cause
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on onditions, mediate environs injury s Last on onditions) Interpretation of the program of the pregnant of the pregna	a. Hypotalian and the second of the second o	to (or as a control or as a co	onsequence of on	atient 3 DOA Cate of Large Man, street, factory, office	CardioVM. 26. Place of Dither: 4 Nursing ury at ork? Yes 2 No	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes eath (Check only or Home 5 Resid 28d. Describe h 28f. Location (S City or Tow	23d. D. M. M. State) 23d. D. M. M. M. M. M. M. M. M. M. M. M. M. M.	ate of deliver lonth ate of deliver lonth Tribute to the state of th	eny Day Year The cause of death bably 4 AUnkr opsy findings avai impletion of cause 2 No Scene
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on ditions, mediate ertying sinjury stast ast pregnant 2 months? No ficant conditions of the co	a. Hype Due b. Due c. Due d. 23c. If yes, 1 Liv 4 Pre 9 Un uns contributing to the second part of the second	to (or as a control outcome of prebirth 2 present at time the person of the control outcome of prebirth 2 present at the control of the control of the control outcome of prebirth 2 present at the control outcome of present at the control outcome of the	onsequence of on	3 DEctopic pregnant 5 Other (specify) the underlying cause of the underlying	candioVM given in Part I. 26. Place of D. Other: 4 Nursing ury at ork? Yes 2 No	23e. Did to 1 Y 24a. Was a autop perfor 1 Yes eath (Check only or Home 5 Resid 28d. Describe h 28f. Location (S City or Tow	23d. D. M. M. M. M. M. M. M. M. M. M. M. M. M.	ate of deliver lonth ate of deliver lonth The problem of Problem of Specific longer or Rural	eny Day Year Day Year Day Year Dably 4 Dunkr Dosy findings availing availin
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on onditions, mediate errlying strain on onditions, mediate errlying strain of pregnant error on ondition on one of the one o	a. Hypotherical and many part of the property	to (or as a control or as a co	onsequence of on	atient 3 DOA catient 3 DOA ne of wry M 11 n, street, factory, office death occurred at the or investigation, in my	candioVM given in Part I. 26. Place of D. Other: 4 Nursing ury at ork? Yes 2 No	23e. Did to 1 Y 24a. Was a autop year perfor 1 Resid 28d. Describe h 28f. Location (S City or Tow	23d. D. M. M. M. M. M. M. M. M. M. M. M. M. M.	ate of deliver to the state of	eny Year Day Ye
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on onditions, mediate errlying rinjury s Last on the pregnant of months? No officant conditions of the conditions	a. Hype Due b. Due c. Due d. 23c. If yes, 10 Liv 4 Pre 90 Un ns contributing to part be 28a. Da gation and be 28e. Pla bu g Physician: To Examiner: On the and m	to (or as a control outcome of prebirth 2 present at time the person of the control outcome of prebirth 2 present at the control of the control of the control outcome of prebirth 2 present at the control outcome of present at the control outcome of the	onsequence of on	atient 3 DOA cate of which is the underlying cause of	candioVM. 26. Place of D. Sther: 4 Nursing ury at ork? Yes 2 No e time, date and place of pointon, death occurs on the property of the	23e. Did to 1 Y 24a. Was a autop year perfor 1 Resid 28d. Describe h 28f. Location (S City or Tow	23d. D. M. M. M. M. M. M. M. M. M. M. M. M. M.	ate of deliver lonth ate of deliver lonth	eny Day Year Day Year Day Scene al Route Number, stated. o the cause(s) Day, Year)
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 1 Yes 2 2 9 1 Unknown Part II. Other signification of Death 12 Natural 2 1 2 Natural 3 1 2 Natural 3 1 2 Natural 3 1 2 Natural 3 1 2 Natural 3 1 2 Natural 2 Natural 3 2 Suicide 4 1 Homicide 29a. Certifier (Check only one) 29b. Signature and	(Final on onditions, mmediate entying injury s Last Int pregnant months? No ficant condition The predict of condition investig 6 Could in determing title of certifier the condition of the co	a. Hype Bue b. Due c. Due d. Due d. Pre 9 Un ns contributing to the late of th	to (or as a control to (or	onsequence of on	atient 3 DOA Content actions of the underlying cause o	26. Place of Dither: 4 \(\text{Nursing ury at lock?} \) \(\text{Yes} \) 2 \(\text{No} \) \(\text{No} \) \(\text{voinion, death occ} \)	23e. Did to 1 Y 24a. Was a autop year perfor 1 Resid 28d. Describe h 28f. Location (S City or Tow	23d. D. M. M. M. M. M. M. M. M. M. M. M. M. M.	ate of deliver lonth ate of deliver lonth	eny Year Day Ye
	disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	(Final on onditions, mediate errlying rinjury s Last at pregnant months? No officant conditions the conditions of the co	a. Hype Bue b. Due c. Due d. Due d. Pre 9 Un ns contributing to the late of th	to (or as a control to (or	onsequence of on	atient 3 DOA Cate of investigation. In my 29c. Lice Output (Specify)	given in Part I. 26. Place of Dither: 4 Nursing ury at ork? Yes 2 No e time, date and place of pointing, death occurs number	23e. Did to 1 Y 24a. Was a autop year perfor 1 Resid 28d. Describe h 28f. Location (S City or Tow	23d. D. M. M. Dibacco use consecutives 2 D. No an symmet? 2 D. No an symmet? 2 D. No an symmet. State) State and Num. State) Sause(s) and many date and place 29d. Date sign.	ate of deliver lonth ate of deliver lonth The problem of the prior to condeath? The problem or Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior of Rural long of the prior	ery Day Year Day Year The cause of death Dably 4 AUnkr Dopsy findings avain Impletion of cause 2 No Scene Al Route Number, Stated. o the cause(s) Day, Year) 26, 2005

DHMH 17 Rev 1/2001

13

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey Physician William F. Ryan Sep. 28, 2005 6:10AM /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore Cherrywood Reisterstown Future Care | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec • 1 2 , 1 9 2 4 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Maryland Director 219-14-1989 80 Usual Residence of Decedent death with the Marylend 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Depertment of Health and Mental Hygiene. Important: If flem 27 is marked other than "neture!", or flems 23e or 28a-f show any Injury or other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes XXNo Director Reisterstown MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21136 134 Chestnut Hill Lane, West Funeral 12. Was Decedent Ever in U,S. Armed Forces? XIXYes 2 □ No If Yes, Give WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. 1 ☐ Never Married XX Married Saltimore, Maryland 21215-0020 1 ☐ Yes XIXNo Specify: Specify: White ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Lydia E. Sullivan 2 Michael Joseph Ryan 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type, Print) 134 Chestnut Hill Ln., West; Reisterstown, MD Patricia K. Ryan / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) 9/30/05 Owings Mills, MD Maryland Veteran Cem. 21. Signature Fineral Service Licens 22. Name end Address of Fecility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 1) Pmantid Years Examiner Due to (or as a consequence of): Examiner ettending physiclen end I for use es the buriel-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed has 1 ☐ Yes 2 No 1 □ Yes 2 □ No After this certificete or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation efter death. Director: Aft 1 Yes 2 No 3 Suicide 6 Could not be determined To the Hospital or Atte within 24 hours effer de To the Funerel Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 35844 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayte 108 Rundellstown MD 21133 Old Court Road 32. Segistrar's Signature 31. Date filed (Month, Day, Year) SEP 2

18 186 A

DHMH 16 Rev 6/95

State

Registrar

			Please	State of Ma	ryland / Depa	artment of I	Health and			•	31671
			Registrar		Cei	rtificate of	Death		Reg. No.	000	• 1 0 1 1
п	Physici	ian	Decedent's Name (First, Middle, Las	st)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		Rita Rose Ruark						26 200		10:08 A M
1	Examir	ner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Deat	h	4c. Co	unty of Deat	h
			14 Bandon Ct. # 5. Social Security Number 6. S		(la use fact high day)	Timon If Under 1 Year		0.5 (5)		Itimor	
	Funeral Director			C C -	(In yrs. last birthday) Yrs.	Months Days			y Year)		hplace (State or Foreign untry)
V.			Usual Residence of Decedent					Islat CI1	4,132	Me Me	0
	yland		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	a-f s	ctor	MD Baltimor	e	Timo	nium					1 ☐ Yes 2 No
	th th	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Co	untry?
	23a	rai	14 Bandon Ct. #	204		210	93			USA	
	tems terms	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14.	Race - Ame Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No					white
Ş	d within 72 hours after deeth with the Maryland Jiene. r than "netural", or Items 23s or 28s-1 show Itte Medical Evaninar must be notified at	ed t	15. Decedent's Ed	Year or Dates:	162 Docor	dent's Usual Occup	nation				
7	in 72	plet	(Specify only highest gra	de completed)	(Givə	kind of work done DO NOT use retire	during most of wor ad)		160. Kind	of Business/l	naustry
212	d within piene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	Field	Services	Coordin	ator	Amari	can C	ancer Socie
ਲੂ	The Hyg	Bec	17. Father's Name (First, Middle, Last)		LACCA	tive occi		ne (First, Middle,			aricer Socie
<u>a</u>	uld be Aental rked c	To E	Louis M. Sleater	, Sr.			Ann R	. O'Con	nor		
Maryland 21215-0036	d 2 should it and Menit and Menit 7 is marketraumatic		19a. Informant's Name/Relationship (7	,, ,	19b. Mailin	ng Address (Street	and Number or Ru			wn, State, Z	lip Code)
	カモトン		Mary Ellen Bates	s/daughter	3436	Widows	Care, Fa	llston, M	ViD 21	047	
ore	S = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Locat	ion - City or 1	Town, State
Ë	Pa Int:		`4 □ Donation 5 □ Other (Specify		National						ch, VA
Baltimore,	permit. Page Department o Important: If any injury or ance.		21. Signature of Funeral Service Licen	and all it	22	Name and Addre	ess of Facility	ome of I	Julane	leV ve	ley, Inc.
	40 = 4 Q			ary	110	W. Padi	onia Ro.	Limoni	um_ r	4D 210	093
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only								Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final / disease or calition resulting in dea h	a. CAR	consequence of):	A 07	I THE	Cos	an	1	13 MONTG
	Examiner		1	Due to (or as a	consequence of):	13/01	,				
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
W	uted	Examiner	Cause (Disease or injury								
ر ر	e be executed /sicien and e burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
760,	te be ysicie ie bur	cai		d							
68	res that the death certificate igned by the attending phys be detached for use as the	Physician/Medi			17						
Вох	th cer endir r use	an/N	200. Was decedent program	23c. If yes, outcome of 1 ☐ Live birth 2	pregnancy	Ectopic pregnancy	.,		23d.	Date of deliv	/ery
	deal	sicia	in the past 12 months?	4☐Pregnant at tir		Other (specify)	у			Month	Day Year
P.O.	The law requires that the ate has been signed by th page 2 should be detache	Phy	9 ☐ Unknown					-			
	igned be d	by	Part II. Other significant conditions co	entributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	_		the cause of death?
ord	w require been si should I	ted						1 U Y	es 2 N	o 3 🗆 Pro	babiy 4 Unknown
ec	e law has b	Completed						24a. Was a		b. Were aut	opsy findings available ompletion of cause of
<u> </u>	The page	Con						perfor	med? 2 No	death? 1 ☐ Yes	
je Ze	cien: ertific ector.	Be	25. Was case referred to medical examiner?	(1				th (Check only or			
<u></u>	shysi this o	မ	1 192 2 240		2 ER/Outpatient	3□ DOA Oth	er: 4 Nursing H	ome 5 Resid	ence 6 🗆	Other (Speci	ify)
U U	ling F After uner	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	28c, Injur Wor		28d. Describe h	ow injury oc	curred	
<u>s</u>	ttend death stor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	One Discount leise			Yes 2 □No				
Division of Vital Records,	after Direc	Certification:	4 Homicide determined	building, etc.	- At home, farm, stre (Specify)	et, factory, office		281. Location (S City or Tow	treet and Ni n, State)	ımber or Rur	ral Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier Cartifying Phy	rsician: To the best of	Ty knowledge death	occurred at the time	To data and place	and due to the			
	e Hos 24 h e Fur etely	edicai	(Check only 2 Madical Exam	iner: On the basis of ex and manner state	camination and/or inv	estigation, in my o	pinion, death occur	rred at the time, d	late and pla	manner as s ce, and due t	stated. to the cause(s)
	ro th ro th compl	Me	29b. Signature and title of certifier	4		29c. Licens	e number	2	9d. Date sig	ned (Month,	Day, Year)
			Walter R.	Welnes	MAD	DA	p. 17	6	En-		
	10		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type, F	Print)	01203	4	1267	17,	2005
_			Walter R. Welzan			•	, Suite	107, Tov	vson,	MD	
2 2	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						

			1 - For State Registrar	State of Marylar		artment	of Health an	-		e 2005	31672
	Physic /Medi		1. Decedent's Name (First, Middle, Las	t)	5+	ewar	-+	2. Date of Month	, D.	ay Year 24 2009	3. Time of Death
	Examii Funeral		4a. Facility Name (If not institution, give Sohn & Hoplich Solid Security Number 6. S.	Hospital		4b. City, To	time/e	eath	4	c. County of Death	h
	Director			□ M 2 ⊠ F 5	Yrs.	Months			Day, Year		hplace (State or Foreign untry) yland
	e Maryla Ba-f ahov	ctor	Maryland Harfor		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X No
	th with th	Funeral Director	10e. Street and Number 843 Clover Lea	f Court		10f. Zip C	ode 1 0 4 0			itizen of What Co SA	untry?
5-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heelth and Mental Hygiene. ortant: If itam 27 is marked other than "natural", or itams 23a or 28a-f ahow injury or other traumatic event. The Medical Eventries must be notified at al. 9.	þ	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates:		Was Deceder If Yes, specify	nt of Hispanic Origin' r Cuban, Mexican, P XNo <i>Specify:</i>	(Specify Yes or Jerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: B1	
21215-(filed within 72 h Hygiene. Ither than "natu	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give		Occupation done during most of retired) ten Stud		16b. I	Kind of Business/I	ndustry
Maryland	should be filed nd Mental Hygi markad other umatic evant, I	To Be (17. Father's Name (First, Middle, Last) William Eric S				Raqy	Name <i>(First, Midd</i> ya Smit	:h		
	es 1 and 2 sho of Heelth and I fitam 27 is ma r other traums		19a. Informant's Name/Relationship (7 William Eric St 20a. Method of Disposition	ewart, Jr.	843		r Leaf C		lgew		
Baltimore,	permit. Pag Department Important: I any injury o		Maurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of uneral Service Licen:	Dul	aney	Valle:	y Mem G	ar. hatman-	Har	ris Fun	Maryland eral Home Md 21215
8760, 安	ate be executed /Medical /Medical Examiner	dical Examiner	23a. Pant Enter the disease, or composition, or heart failure. List only of insease or condition resulting in death) Sequentially list conditions, insease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):		strocy				Approximate Interval Between Onset and Death 48 Keeps
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□	Ectopic pregr Other (special				23d. Date of deliv	rery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ui	nderlying caus	e given in Part I.			_	the cause of death?
Vital Record		Completed							s an opsy formed? 22 No	prior to co death?	opsy findings available ompletion of cause of
of	Attanding Physician: r death. actor: After this certific by the funeral director,	ation; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Peath Shatural 5 Pending investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time of Injury		Other	Death (Check only) Home 5 Res 28d. Describe	sidence	6	(y)
=	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, of	fice	28f. Location City or To	(Street an own, State	d Number or Rura s)	ul Route Number,
	Ho Funda	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the estigation, in	ne time, date and pla my opinion, death o	ce, and due to the curred at the time	cause(s) , date and	and manner as s place, and due to	tated. the cause(s)
)	To the To the Complet	Σ	29b. Signature and title of certifier	MO, PhD			cense number			te signed (Month,	
	3		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, I	erint) fins H	opicins Ho	same.	BA	MMORE	21287
)	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2	32. Paistrar's Signat	de A	barle					0

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:31 p M September 26 2005 THELMA STOKES /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOSEPH RICHIE HOSPICE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 19 1954 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2X F Yrs. 51 MARYLAND Director 214-62-8848 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Medical Examinar must be notified at 1 Yes 2 No BALTIMORE MARYLAND N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 4505 MANASOTA AVENUE 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2√XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: ₩Widowed 4 Divorced BLACK "natural" Completed 15, Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) UNION MEMORIAL HOUSEKEEPING 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fill timent of Health and Mental H tent: If Item 27 is marked oth jury or other treumatic even VIRGINIA JENKINS JAMES W QUEEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 Hyacinth DR., Apt 104, Pennsacola, Fla., 32506 Veronica E. Cooper/Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 10-01-05 LANSDOWNE, MARYLAND 21. Signatur of Funeral Service Licensee 22 Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Misu implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest niy one cause or leach line. Approximate Int n al Betweer Ondet n Deat Part1. Enter the disease, or coshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown O 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 3 Probably 4 Dinknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 🗆 1/0 Vital 25. Was case referred to examiner? funeral director, Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Pher (S.) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ot 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No M within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date soned (Mon. J. Day, Year) 29b. Signature and title of certifier h 31. Date filed (Month, Day, Year State Registrar

		1 - State	State of Marylar		artment of rtificate of			jiene 10g. Na2 () (15	3167	L
		Registrar 1. Decedent's Name (First, Middle, Las	it)				2. Date of Dea	ith	J U	3. Time of Death	
Phys		M. Euphrasia S	imkonis				Month 09	26 20	Year 005	8:15p	М
	dical niner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea		4c. County		L	
		4100 Maple Aver	nue		Balt	imore		Ba1	timor	e	
Funer Directo		199 40 0880	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			Year) 1908	_ Coun	lece (State or Forei try) Sylvania	gn
and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1-	Od. Inside City Limi	ts
Maryl f sho	ō	Maryland Baltimo	re l	Baltimo	re					1 Yes 2 N	10
the t	Directo	10e. Street and Number	10 1	our crime	10f. Zip Code			10g. Citizen of W	/hat Coun	try?	_
h with	0	4100 Maple Ave	nue		21	227		U.S.			
deet	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race	- Americ k, White,		
ING Z1Z13-UU36 be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or flams 23e or 28e-f show event, the Medical Exeminating mail be notified at	y Fu	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 No If Yes, Give		1□Yes 2√□No		,		Whit		
hours tural	ed by	3 Widowed 4 Divorced	Year or Dates:	162 Daca	dent's Usual Occu	nation		16b. Kind of Bu			
n 72 nation	lete	15. Decedent's Ed (Specify only highest grades)	de completed)	(Give	kind of work done DO NOT use retire	during most of w	orking	160. KING OF BU	211622/1110	lustry	
with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Nun				Religio	us Si	ister	
nd A	BeC	17. Father's Name (First, Middle, Last)					ame (First, Middle,				
Vial build by Menta Menta arked	70 B	Franc	is Vincent Sir	nkonis		Mar	garet Mag	dalen D	eres	cavage	
and and and and and and and and and and		19a. Informant's Name/Relationship (7 Sr. Kathleen Moo	**				Rural Route Numbe	-			
e, N 1 and 1 Health em 27		<u> </u>			Maple Av		Baltimore Date	20c. Location -			
Baitimore , permit. Peges 1 ar Depertment of Healimportant: If Item any Injury or other		20a. Method of Disposition 1 🖫 Burial 2 ☐ Cremation 3 ☐			natory or other pla						
ti Pe rimen riant:		' 4 □ Donation 5 □ Other (Specify		w Cathe	edral Cer	netery 9/2	29/2005 Gonce Fun	Baltimoi	ce, M	aryland	_
Baitim permit. Peg Depertment Important: I	once	21. Signature of Funeral Service Licen	See .	//			way Balt				5
		23a, Part1. Enter the disease, or comp	lications that caused the dea						ICI Y I	Approximate	
Dh		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	4:	olon (~			•	Onset and Death	1.
Physicia /Medic		disease or condition resulting in death)	a. Due to (or as a consec		0154	Line 21			4	_ pront	
Examine	er										
		Conventially list conditions	h								
/ D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quenca of):							
ecuted and transit	caminer	that initiated events	Due to (or as a consuc								
be executed cien and burial-transit	al Examiner	Cause (Disease or injury									
icate be executed physicien and s the burial-transit	cal	that initiated events	Due to (or as a consuc								
OX 68/60, Certificate be executed admin physicien and use as the burial-transit	cal	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect d	quence of):				23d. Date	e of delive	ry	
BOX 68 / 60, / / Geath certificate be executed settending physicien and dror use as the burial-transit	cal	Cause (Disease or injury that infitted events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?	c. Due to (or as a consect d. 23c. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of	quence of): ancy al death 3	Ectopic pregnanc	:y		23d. Date Mor		ry Day Year	
the death certificate be executed by the ettending physicien and lached for use as the burial-transit	cal	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3		:y				•	
hat the do do by the detached	cal	Cause (Disease or injury that infiliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 Yes 2 Vo	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3 [death 5 [Other (specify)			Mon	bute to th	Day Year	
hat the do do by the detached	cal	Cause (Disease or injury that infiliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Oo 9 Unknown	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3 [death 5 [Other (specify)		23ə. Did to	Mon	bute to th	Day Year	m
requires that the digeneral signed by the hould be detached	cal	Cause (Disease or injury that infiliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Oo 9 Unknown	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3 [death 5 [Other (specify)		1 □ Y 24a. Wasa autop:	bacco use contri	bute to th	Day Year	ole
I HECOTGS, P.O. The law requires that the diate has been signed by the page 2 should be detached	cal	Cause (Disease or injury that infiliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Oo 9 Unknown	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3 [death 5 [Other (specify)		1 ☐ Y	bacco use contri	bute to th	Day Year e cause of death? ably 4 Unknow	ole
I HECOTGS, P.O. The law requires that the diate has been signed by the page 2 should be detached	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II, Other significant conditions or the conditions of	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3 death 5 death 5 death 5 death 5 death	Other (specify) nderlying cause gi	ven in Part I. 26. Place of De	1 Yas autop perfor 1 Yes	bacco use contri es 21000 in 24b. V by med? d 20000	bute to th I problem Ore autorior to coneath? Yes	Day Year e cause of death? ably 4 Unknow osy findings availab	ole
OT VITAL MECOTORS, P.O. Physician: The law requires that the di this certificate has been signed by the al director, page 2 should be detached	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Volo 25. Was case referred to medical examiner? 1 Yes 2 Volo	Due to (or as a consect of the conse	quence of): ancy al death 3 death 5 death 6 d	Other (specify) nderlying cause gi	ven in Part I. 26. Place of De	1 Yes 24a. Was a autop perfor 1 Yes aath (Check only or	bacco use contri	bute to th 3 Proba /ere autoprior to conseath? Pes	Day Year e cause of death? ably 4 Unknow osy findings availab	ole
OT VITAL MECOTORS, P.O. Physician: The law requires that the di this certificate has been signed by the al director, page 2 should be detached	To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Woo 9 Unknown Part II Other significant conditions or warminer? 1 Yes 2 Woo 27. Manner Death 1 Death Pending	Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregn 1	quence of): ancy al death 3 death 5 death 5 death 5 death 5 death	Other (specify) nderlying cause gi at 3 DOA t 28c. Inju.	ven in Part I. 26. Place of De	1 Yas autop perfor 1 Yes	bacco use contri	bute to th 3 Proba /ere autoprior to conseath? Yes	Day Year e cause of death? ably 4 Unknow osy findings availab	ole
OT VITAL MECOTORS, P.O. Physician: The law requires that the di this certificate has been signed by the al director, page 2 should be detached	To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1	Due to (or as a consect Due to (or as a consect d	quence of): ancy al death 3 death 5 death 6 d	Other (specify) nderlying cause gr at 3 DOA 0 t 28c. Inju M 1	26. Place of Dehen: 4 □ Nursing	24a. Was a autop: perior 1 Yes eath (Check only or Home 5 Yesid 28d. Describe h	bacco use contri es 2000 in 24b. W in 24b. W in 24b. W in 24b. W in 34b. W in 45b. W in 45b. W in 45b. W in 55b. W in 65b.	bute to th 3 Probi /ere autor ior to con eath? Yes	Day Year e cause of death? ably 4 □Unknow sy findings availab apletion of cause of	ole
OT VITAL MECOTORS, P.O. Physician: The law requires that the dithis certificate has been signed by the all director, page 2 should be detached	To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1	Due to (or as a consect of the conse	quence of): ancy al death 3 death 5 death 6 d	Other (specify) nderlying cause gr at 3 DOA 0 t 28c. Inju M 1	26. Place of Dehen: 4 □ Nursing	24a. Was a autopup perfor 1 Yes eath (Check only or Home 5 Nesid	bacco use contri es 2000 in 24b. W in 24b. W in 24b. W in 24b. W in 34b. W in 45b. W in 45b. W in 45b. W in 55b. W in 65b.	bute to th 3 Probi /ere autor ior to con eath? Yes	Day Year e cause of death? ably 4 □Unknow sy findings availab apletion of cause of	ole
OT VITAL MECOTORS, P.O. Physician: The law requires that the dithis certificate has been signed by the all director, page 2 should be detached	Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 more of the past 12	Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of or 9 Unknown ontributing to death but not res 27 2 Husting to death but not res 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h building, etc. (Speci	ancy al death 3 death 5 death 6 death	nderlying cause grant 3 DOA Ct 28c. Inju. M 1 ceet, factory, office	26. Place of De ther: 4 \(\text{Nursing} \) ry at rk? 1 Yes 2 \(\text{No} \) No	24a. Was a autopup perfor 1 Yes eath (Check only or Home 5 Neside 28d. Describe h	bacco use contributions 210 No 10 10 10 10 10 10 10 10 10 10 10 10 10	bute to th 3 Probi fere autoprior to coneath? If (Specify) If (Specify	Day Year e cause of death? ably 4 Unknow one findings available of cause of the cau	ole
OT VITAL MECOTORS, P.O. Physician: The law requires that the di this certificate has been signed by the al director, page 2 should be detached	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1	Due to (or as a consect Due to (or as a consect d	ancy al death 3 death 5 death 6 death	nderlying cause grant 3 DOA of 28c. Inju. Wo M 1 reet, factory, office th occurred at the treestigation, in my	26. Place of De her: 4 \(\text{Nursing} \) No sime, date and place opinion, death occ	24a. Was a autoportor yes at the Check only or Home 5 Nesid 28d. Describe h 28f. Location (S City or Tow	bacco use contri es 21 No in 24b. W per d d 22 No 1 ee) ence 6 Othe ow injury occurre freet and Number n, State) ause(s) and mar ate and place, a	bute to the superior to conseath? If yes a superior to consea	Pay Year e cause of death? ably 4 Unknow easy findings available appletion of cause of the cause of the cause of the cause(s)	ole
VITAL RECORDS, P.O. sician: The law requires that the d certificate has been signed by the lirector, page 2 should be detached	Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1	Due to (or as a consect Due to (or as a consect d	ancy al death 3 death 5 death 6 death	nderlying cause grant 3 DOA of 28c. Inju. Wo M 1 reet, factory, office th occurred at the treestigation, in my	26. Place of De ther: 4 \(\text{Nursing} \) ry at rk? 1 Yes 2 \(\text{No} \) No	24a. Was a autoportor yes at the Check only or Home 5 Nesid 28d. Describe h 28f. Location (S City or Tow	bacco use contri es 21 No in 24b. W pmed? d 22 No 1 ence 6 Othe ow injury occurre treet and Number n, State) ause (s) and mar ate and place, a	bute to the superior to conseath? If yes autoprior to conseath? If (Specify) If or Rural to the superior or Rural to the superior of the su	Day Year e cause of death? ably 4 Unknow asy findings availabe apletion of cause of 2 (T) Mo Route Number, ated. the cause(s)	ole f
OT VITAL MECOTORS, P.O. Physician: The law requires that the di this certificate has been signed by the al director, page 2 should be detached	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1	Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregn 1	ancy al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 death	nderlying cause grant 3 DOA of 28c. Inju. Wo M 1 creet, factory, office th occurred at the treets wastigation, in my 29c. Licen	26. Place of De her: 4 \(\text{Nursing} \) No sime, date and place opinion, death occ	24a. Was a autoportor yes at the Check only or Home 5 Nesid 28d. Describe h 28f. Location (S City or Tow	bacco use contri es 21 No in 24b. W pmed? d 22 No 1 ence 6 Othe ow injury occurre treet and Number n, State) ause (s) and mar ate and place, a	bute to the superior to conseath? If yes autoprior to conseath? If (Specify) If or Rural to the superior or Rural to the superior of the su	Day Year e cause of death? ably 4 Unknow asy findings availabe apletion of cause of 2 (T) Mo Route Number, ated. the cause(s)	ole f
OT VITAL MECOTORS, P.O. Physician: The law requires that the di this certificate has been signed by the al director, page 2 should be detached	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last	Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregn 1	ancy al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 death	nderlying cause grant 3 DOA of 28c. Inju. Wo M 1 creet, factory, office th occurred at the treets wastigation, in my 29c. Licen	26. Place of De her: 4 Nursing ry at rk? Yes 2 No ime, date and place opinion, death occurs a number	24a. Was a autopoper of the performance of the perf	bacco use contri es 21 No in 24b. W pmed? d 22 No 1 ence 6 Othe ow injury occurre treet and Number n, State) ause (s) and mar ate and place, a	bute to the superior to conseath? If yes autoprior to conseath? If (Specify) If or Rural to the superior or Rural to the superior of the su	Pay Year e cause of death? ably 4 Unknow easy findings available appletion of cause of the cause of the cause of the cause(s)	ole f
DIVISION OT VITAL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the divinity Et hours alter death. To the Euneral Director: After this certificate has been signed by the completely filled in by the funeral director page 2 should be detached	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infilated events resulting in death) Last	Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregn 1	ancy al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 death	nderlying cause grant 3 DOA of 28c. Inju. Wo M 1 creet, factory, office th occurred at the treets wastigation, in my 29c. Licen	26. Place of De her: 4 \(\text{Nursing} \) No sime, date and place opinion, death occ	24a. Was a autopoper of the performance of the perf	bacco use contri es 21 No in 24b. W pmed? d 22 No 1 ence 6 Othe ow injury occurre treet and Number n, State) ause (s) and mar ate and place, a	bute to the superior to conseath? If yes autoprior to conseath? If (Specify) If or Rural to the superior or Rural to the superior of the su	Day Year e cause of death? ably 4 Unknow asy findings availabe apletion of cause of 2 (T) Mo Route Number, ated. the cause(s)	ole f

Donald Eugene Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item/23a, b. PIT 27, 28a-f. perME 6848,10/12/05 TT State of Maryland / Department of Health and Mental Hygiene 05-06560 crn Reg. No. 2005 State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 26, 2005 **Physician** Donald Eugene Scott 11:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 412 Hillview Drive, Apartment 301 Linthicum Heights Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 6, 1960 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∰M 2□F 213 80 5547 45 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examinar must be notified at 1 ☐ Yes 2x No Maryland Directo Linthicum Heights Anne Arundel 10g. Citizen of What Country? 10e. Street and Number à U.S. 412 Hillview Drive Apt. 301 21090 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 5 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced netural Completed The Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Master Machinist Steelworker 12th other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Pages 1 and 2 should be timent of Health and Mentatant: If tem 27 is marked Dawn A. Hansen Jon Pearson Scott ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zîp Code) Baltimore, Maryland 21226 Dawn Elliott / Mother 1517 Sycamore Street 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Meadowridge Mem. Park 9/30/2005 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 manual 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Choking /Medical Due to (or as a consequence of): Examiner Aspiration of Foreign Object Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical ğ 23c. tf yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cocaine and Zolpidem Use 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) at Scene 12 Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death Date of Injury Find Time of (Month, Day Year) 28c. Injury at Work? After 5 Pending s after dec. 1 Natural 1 Yes XNo investigation 9/26/05 11:48 A^M 2 Accident <u>Subject choked on foreign object</u> 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **412 Hillview Drive** filled in by determined 4 Homicide Found at home To the Hospital within 24 hours a To the Funeral C Linthicum Heights, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME September 27, 2005 raus 30 Name and address of pelson who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year MAYNEL Μ. SMITH 7:15 SEPTEMBER 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CITY SINAI HOSPITAL OF BALTIMORE BALTIMORE N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

7. Age (In yrs. last birthday) Months Days Hours Min. 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ F 217 70 1725 Director MAY 17,1933 JAMICA Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director MD. Yes 2□No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5302 GIST AVENUE 21215 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑No Specify: BLACK 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. markad othar than Elementary/Secondary (0-12) College (1-4or 5+) 8тн HOME HEALTH AID PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be ပ RALPH O'CONNOR CORA SPENCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a BASELL SMITH /SON 4004 SOUTHERN AVE. BALT, MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State jo Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ō permit. Page Department of Important: If any injury or once. SoftathiocT.3,2005 nature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE GASTRIC CANCER ZHTMONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COLON CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical the ! IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, HYPERTENSION 1 ☐ Yes 2 ☐ No 3x Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has perform 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident investigation 1 Tes 2 No after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours at To the Funeral D 12. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTENBER, 26TH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V EUGENIO CINCOLANI MY HOSPITAL OF SINAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2005 Registrar

EDWARD TINDALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item: 190 per inf 19865, 3-14-07 wt and Mental Hydriana

	Registrar		Cei	tificate of i	Deam		Reg. No.	UU	3167
	1. Decedent's Name (First, Middle, Last)				2. Date of D	-	Vanz	3. Time of Death
hysician /Medical	Edward Van Buren	Tindall				Septem		Year 2005	6-10-04
	4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County	of Death	
	Sinai Hospita	1 of Balt	IMOR	Baltim	101E (ity			
al ⁵	5. Social Security Number 6. Se	XM 2□F	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir). (Month, D	ay, Year)	Coun	lace (State or Foreig
or	249-14-7958	AM ZUF	95 Yrs.			June 2	0, 1910	South	n Carolina
I -	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10	0d. Inside City Limits
ō	South								1 XYes 2 No
Director	Carolina Sumter 10e. Street and Number	S	umter	10f. Zip Code			10g. Citizen of V	What Coun	tn/2
٥		-1- D1		29150	1				•
era	10 Alligator Bran	12. Was Decedent Eve	r in U.S. 13. \				United S	e - America	
To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 █️XNo If Yes, Give Year or Dates:	i	Was Decedent of H f Yes, specify Cuba I □ Yes 2☑No	Specify:	rto Rican, etc.)	Specify	k, White, e	etc.
<u> </u>	15. Decedent's Edu	cation	16a. Dece	lent's Usual Occup	ation		16b. Kind of Bu		
Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of w	orking			
E 0	8	College (1-401 34)	Carper	nter			Contrac	ting	
Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden Sumam	18)	
10 E	Edward Van Buren	Tindall, Sr			May Bel	1 Smilin	ıg		
	19a Informant's Name/Relationship (7) Heyward - Hayward Tinda11/Se	pe, Print)		g Address <i>(Street a</i> Beehler A	and Number or F	Rural Route Numb	er, City or Town,		Code)
1 2	20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location -		wn, State
	1 Magazial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Bethesda	Baptist	e) Con	20 2005	Mannina	C.C.	
	21. Signature of Funeral Service Jacons	11.0	Church Ce				Manning	, 50	
9000	Mancie Li	Kgo ANDI	10 Pa	Name and Address almer Mem 04 S. Mai	n St	P.O. Box	2127, S	umter	sc 2915
	23a. Part1. Enter the disease of complishock, or heart failure. List only of	ications that caused the ne cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Acute	myoco		infara	tion			Onset and Death
il r	resulting in death)	Due to (or as a co							
	Sequentially list conditions,)							
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequance of).						1
am	that initiated events resulting in death) Last								
0	resulting in additity East	Due to (or as a co	onsequence of):						
dicai		J		<u>-</u>				-	
	IF FEMALE:	3c. If yes, outcome of p	rozcy						
Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Dat Mor	e of deliver	ry Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	e or death 5	Other (specify)					•
P.	Part II. Dther significant conditions con	ntributing to death but no	ot resulting in the ur	deriving cause give	on in Part I	23a. Did	tobacco use contr	ibute to the	e cause of death?
5		3		,g caaco g					ably 4 Munknown
etec									
Completed						24a. Was	psy p	Vere autop Fior to com leath?	sy findings available pletion of cause of
							2 No 1	Yes	251×6
00	25. Was case referred to medical examiner?	lospital:		04		eath (Check only	one)		-
2	TO THE ZEE ING	Inpatient	2 ER/Outpatien		4 🗀 14 di 3 ili g		dence 6 Othe)
no i	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occurr	ed	
cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Place of laive.	A. h		Yes 2 □ No	cos I continu	C4		0
Certification	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	et, factory, office		City or To	Street and Numbe wn, State)	er or Hurai	Houte Number,
-	(Check only 2 Medical Exami	sician: To the best of m	amination and/or inv	occurred at the timestigation, in my op	e, date and place	e, and due to the	cause(s) and mandate and place, a	nner as sta	ited.
Medical Cel	one) 29b. Signature and title of certifier	and manner stated.	•	29c. License			29d. Date signed		
-	255. Signature and title of Certifier	1.40				01			
	10 mil	MC		Kesid	ent - 1	1076	septemb	er z	3,2005
λ I=	30. Name and address of person who co	impleted cause of death	(Item 23a) (Type, I	Print)					
		1/ 1/0	C	: 14	- 1- 1	-/ -	2 - 111	0 0 0 0	
1		mpleted cause of death MD 32. Registrar's	Sina	i Hospi	tal.	01 1	Baltimo	ore.	

Maryland / Department of Health and M Certificate of Death	ental Hygien 2005	3 1	6	7	8
Certificate of Death	Reg. No.		U		V

			1 - For State Registrar	State of Maryland		artment of i tificate of		ı mental H	reg. No.	2005	31678
	Physici	an	1. Decedent's Name (First, Middle, Last		10			2. Date of D	eath	00 X980=	3. Time of Death
	/Medio Examir	cal	STANLEY VELDR' 4a. Facility Name (If not institution, give	ELL THOMAS	, JK	4b City Town	or Location of De	Septer		22, 2005	03:09 AM
	LXaiiii	101	University Hospita		a		imore			NA	
	Funeral Director		5. Social Security Number 6. Se. 213 · 86 · 8711 Usual Residence of Decedent	7. Age (In yrs. la MM 2□F 35	est birthday) Yrs.	If Under 1 Year Months Days			irth ay Year) 1970	9. Birthp Cour	olace (State or Foreign ntry)
	yland how		10a. State 10b. County		, Town or Lo					1	0d. Inside City Limits
	he Ma	Director	MD N/A	BALT	Timori	7					1 XYes 2 No
	3a or 3		3012 MARDELL I	AVENUE		10f. Zip Code	230		10g. Citia	zen of What Coun	itry?
	ms 2	Funeral	00111 1111111 200	12. Was Decedent Ever in U.S Armed Forces?	6. 13. V			(Specify Yes or Nerto Rican, etc.)	0- 1	14. Race - Americ Black, White,	an Indian,
21215-0036	d within 72 hours after death with the Maryland jiene. Ir then "natural", or Items 23a or 28e-f ehow the Mudical Examirer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ⚠Yes 2 ☐ No If Yes, Give Year or Dates:	1	l□Yes 2 <mark>Ø</mark> No	Specify:	ono moun, etc.,		Specify: BLA	1
75	nin 72 in nat	plete	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retire	pation i during most of w ad)	vorking	16b. Kir	nd of Business/Inc	lustry
	filed within Hygiene. Ither then "I	Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	PAI	NTER			RES	IDENTIA	ıL
Maryland	d be fill intal H	Be	17. Father's Name (First, Middle, Last) STANLEY V. THOY	100 50			18. Mother's N	ame (First, Middle			
ary	should and Men a marke umatic	ဥ	19a. Informant's Name/Relationship (Ty	/	19b. Mailin	g Address (Street	1	Rural Route Numi	BROOK ber, City or		Code)
	s 1 end 2 should be filed if Health and Mental Hyg Itam 27 is marked otha other treumatic event,				11101	TWOSO	_	, SAN			0
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	temoval from State	metery, crem	sition (Name of natory or other pla	· 1	Date		cation - City or To	WATER TO
attin	in production		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensi		ENMO			30.05		TMORE	, MD
ă	Depart Depart Impo		Naughn ()		515	si balto.	NATE PI	UNERAL :	om .c	21229	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. ne cause on each line.	Do not ente	er the mode of dyn	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (of as a conseque		nds					
	Examiner		Sequentially list conditions)	silos oi).						
V	ed	ulner	Sequentially list conditions, fair, leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to (or se a conesque	inde off:						
Š	execution and ial-tract	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
68760,	rificate be executed og physicien and as the burial-transit	ledical		1							
	certific iding p		fF FEMALE:	3c. If yes, outcome of pregnant	cv						27,000
P.O. Box	To the Hospitei or Attending Physicien: The law requires that the death cer within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the ettendin completely filled in by the funeral director, page 2 should be detached for use	by Physician/A	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3□	Ectopic pregnanc Other (specify) _	у		23	3d. Date of delive Month	ry Day Year
S,	es tha igned I be det	by P	Part II. Other significant conditions con	tributing to death but not result	ting in the un	derlying cause gru	ven in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
Division of Vital Records,	v requi	Completed						·	Yes 2		ably 4 Unknown
Re	The lav	dmo							psy ormed?	death?	osy findings available apletion of cause of
ita	sien:] artifice ctor. p	Be C	25. Was case referred to medical examiner?				26. Place of D	ath Check only	2□No one)	1 Yes	2□ No
o t	Physic this caral dire	2	1 X Yes 2 No H		R/Outpatient		4 🗆 Mulsing	Home 5 ☐ Res)
on	nding th. r: After e fune	atlon	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. injur Wor ↓ M 1 □	ryat rk? Yes 21⊠No	28d. Describe			
Vis	r Atte ter des irector	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of fnjury - At hom building, etc. (Specify)				28f. Location (Street and	Number or Rural	
	pitei o ours af erei D		29a. Certifier 1 ☐ Certifying Phys	str				400 Hod	c of w		Bellimore, MD
	n 24 hi ne Fun iletely	edical	(Check only one)	sician: To the best of my knowler: On the basis of examination and manner stated.	edge, death on and/or invi	occurred at the tire estigation, in my c	me, date and place opinion, death occ	ce, and due to the curred at the time,	date and p	and manner as sta place, and due to	ited. the cause(s)
	To the To the comp	W	29b. Signature and title of certifier			29c. Licens				signed (Month, D	
•			Jos bogy	ser no			O.C.M.E			ember 22	
	7		30. Name and address of person who co Tasha Zereen	beig M.D	111 l	Penn Str	eet, Bal	timore,	Mary1	and 2120)1
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2	Registrar's Signatu							

CT05-06145 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tucker, Donna State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a&27 per me G847 9-30-05 tas

Certificate of Death Reg. No. Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Donna Marie Tucker **Physician** September 8, 2005 8:22 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Westminster 2436 Tyrone Road 5. Social Security Number 6. Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Months Days Yrs. 43 Dec 29, Director 1961 Maryland nnkUsual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 United States 2436 Tyrone Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: White Completed by Specify 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Health Care Worker State Government other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fill of Health and Mental Hittam 27 is marked other Be Mary K. Schwartz ဂ William R. Teves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Teves / Father 2436 Tyrone Road, Westminster, Maryland 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 0 = 6 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: if any injury or once. Lake View Mem. Park 9/12/05 4 ☐ Denation 5 ☐ Other (Specify) Sykesville, Maryland nature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 4)Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1X Yes 2 🗌 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home SXXHesidence 6 Other (Specify) 1 XYes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ANatural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending efter death. Diractor: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

State Registrar

DHMH 17 Rev 1/2001

ATRICIA

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mron.ca

TOTAK MD

32. Registrar's Signature

OCME

September 9, 2005

111 Penn Street, Baltimore, Maryland 21201

	1 - For Amend Items 23a, Pt	of Maryland / Depart Dr. Ce	artment of Health and N 34,7,09/29/05dhb	Mental Hygiei	2005 31680
Physician	Decedent's Name (First, Middle, Last) ARTHUR	THOMCON		2. Date of Death	Day Year 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and n	THOMSON umber)	4b. City, Town, or Location of Death		4c. County of Death
	Greater Baltimore Medic		Towson		Baltimore
Funeral Director	5. Social Security Number 6. Sex 1 M 2 □ F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 8/31/1923	
	Usual Residence of Decedent			0/51/1925	NEW YORK
death with the Maryland ms 23a or 28s1 show triust be rediffed at a rediffed at a reral Director	10a. State 10b. County MD BALTIMORE	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the Mar t or 28a-f • De routified	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
th with	8650 BLACK OAK ROAD		21234		USA
	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. 13. orces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
1215-0036 vithin 72 hours after energy for the Madical Examination	_ If Yes, G	2 □ No Sive Dates: WWTT	1 ☐ Yes 2 ☐ No Specify:		Specify: WHITE
altimore, Maryland 21215-0036 altimore, Maryland 21215-0036 mil. Pages 1 and 2 should be filed within 72 hours att partnent of Health and Mental Hygiens portant: if item 27 is marked other then "natural; or y injury or other traumatic event, the Medical Exert cq. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed	16a. Dece	tent's Usual Occupation kind of work done during most of work	16b	. Kind of Business/Industry
Ind 21215-0 be filed within 72 he tall Hygiene. event, the Medical be Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	DO NOT use retired)		
and 2. See filed vital Hygic event, by Be Co	12TH GRADE 17. Father's Name (First, Middle, Last)	GRC	CERY CO. 18. Mother's Nam	e (First, Middle, Maio	CTAIL SALESMAN (en Sumame)
Baltimore, Maryland 21215 Baltimore, Maryland 21215 Departie. Pages 1 and 2 should be filed within 7 Departies of Health and Mental Hygiens Departies of Health and Mental Hygiens The marked other then " may injury or other traumatic event, the Med Dece. To Be Comple	ARTHUR THOMSON		MURIEL	LAWRENCE	
MSCN, Anore, Maryla ges 1 and 2 should not Health and Mento or other traumatic or other traumatic	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rui		
1501 or Health itsm 27	EDNA E. THOMSON/WIFE 20a. Method of Disposition	8650 20b. Pface of Dispo		BALTIMORE,	MD 21234 Location - City or Town, State
mor mor mor mor mor mit if it	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State GARRISON	FOREST 0/27		INGS MILLS, MD
Baltimol Bernit. Pages permit. Pages permit. Pages permit. Pages Importantial in any injury or ones	21. Signature of Funeral Septice Licensee	VETERANS	CEMETERI		FUNERAL HOME, P.A.
Ba and be	Heather D. He	ufer 8	521 LOCH RAVEN BL	VD. TOWSO	N, MD 21286
· Physician /Medical	resulting in death)	pected Pitt	er the mode of dying, such as cardiac pulmonary emboling noncery emboling	ism	Approximate Interval Between Onset and Death 1 day
Examiner	Cu	o (or as a consequence of):	pication		2 1/21
W = E	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	(۲		75
8760, ate be executed shysicien and the burial-transit did Examiner	trial initiated events	o (or as a consequence of):	lar disease		
8760, cate be exphysicien the burial	333,0	(or as a consequence or).			
	0.				
P.O. Box 68 that the death certific ed by the attending pl detached for use as the physician/Med	in the nest 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to a Aspiration pneu	monia, cerebr	oderlying cause given in Part I. OVASCULAR disease		o use contribute to the cause of death? 2 ♣ No 3 ☐ Probably 4 ☐ Unknown
II Record The law requi	Acute oliguric	renal failure		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The cate h page				performed?	death?
of Vital F Physician: Th this certificate ral director, pag.	25. Was case referred to medical examiner? Hospital:		0.15	Check only one)	
Of N Physi or this of Bral dir	27. Manger of Death 28a. Date	Inpatient 2 ☐ ER/Outpatien of Injury 28b. Time of nth, Day Year) Injury		me 5 Residence 28d. Describe how in	6 ☐Other (Specify)
Vision (Attending Is ector: After by the funer of Ification)	1 Natural 5 □ Pending (Mor 2 □ Accident investigation	nth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		. ,
Division of Vital Records, tall or Attending Physician: The law requires t is effect death. al Director: After this certificate has been signe ed in by the funeral director, page 2 should be certification; To Be Completed by	3 Suicide 6 Could not be determined 28e. Plac build	e of Injury - At home, farm, stro ding, etc. (Specify)	est, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, tte)
Division of Vital Reconstruction of Vital Reconstruction of Vital Reconstruction of Vital Reconstruction of the Hospital or Attending Physician: The law within 24 hours effor death. To the Funeral Director: Affor this certificate has completely filled in by the funeral director, page 2.	(Chock only 2 Medical Examiner. On the t	e best of my knowledge, death basis of examination and/or inv nner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. Individual place, and due to the cause(s)
To the weithing To the company	29b. Signature and title of certifier	7	29c. License number	29d. D	Date signed (Month, Day, Year)
	"Manh Josnell	ND	1002808	2 9	1/21/05
	30. Name and address of person who completed cau	se of death (Item 23a) (Type,	Print) RVIII PO	Upst 7	WELL MADDROY
State	31. Date filed (Month, Day, Year) \$32. F	Registrar's Signature	1.	7	I VCVV

00243		1	For Unpe	nd Ite	m 23a	State o	f Mar [I,2 7	yland pe	d/Dep r me e	artmen C8/17 rtificat	t of H 9-30	ealth a	and Nas	Mental H	ygier	ne v20	05	31	681
Dhuo	eion	1.	Decedent's Name											2. Date of D	eath			3. Time	of Death
Phys /Me	dical		John Ulr							,				Septe	mber	ź 11,	2005	1:05	5 p. м
Exan	niner		Facility Name (If		-			١				Location	of Death			4c. County			
			Southern Social Security No		and H	ospit					Clin	If Under	24 U.s.	· ·			e Geo		
Funer Directo		3.	Social Security IV	unk		2□ F		111 yrs. ia 8	st birthday Yrs.	Months		Hours	Min.	B. Date of B	irth Day, Yea	947	9. Birthp Coun	lace (State try)	e or Foreig unk
9		U	sual Residence of										L	7					- unk
urylar show	_		Da. State	10b. County			10		Town or L							_	1	0d. Inside	City Limits
Sa-1	Scto		MD		nce G	eorge	s	C:	linto	n								1 □ Ye	es 2√∑No
with th	吉	10	e. Street and Nun		Daad					10f. Zip		_			10g. (Citizen of	Whal Coun	itry?	
eath ma 23	era	-	8201 Woo			Was Dece	dent Eus	er in II S	12		2073		-1-2 (0-			14 D-	A		nk
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours elter death with the Maryland s 1 and 2 should be filed within 72 hours elter death with the Maryland flem 27 is marked other than "natural", or Itama 23a or 28a-1 ahow other traumatic avant, the Medical Examinar must be notified at	by Funeral Director		1 Never Marrie		ied	Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2.⊠No ⁄e	91 111 0.3	. 13.	Il Yes, spec		Specify:		pecify Yes or N Rican, etc.)	10-		ce - Americ ck, White, v: whi	etc.	
2 ho	ted		/S-22	15. Deceden				T	16a. Dece	dent's Usua	al Occupa	ition			16b.	Kind ol B	usiness/Ind		
21: Phin 7	Be Completed	-	Elementary/Secon	i <i>fy only highe</i> ndary (0-12)		College (1	-4or 5+)	-	life.	kind of wo DO NOT u	rk done d se retired	uring mos)	t of work	king					
21 ed wi	ပ္ပ	L		unk			unl	k						unk					unk
be fill Hall Hall Hall Hall Hall Hall Hall H		17	'. Father's Name (First, Middle,	Last)					unk		18. Mothe	er's Nam	e (First, Middle	e, Maide	en Suman	n <i>e)</i>		unk
Taryland 2121 2 should be filed within and Mental Hygiane. Is marked other than aumatic avant, the Mis	2	19	9a. Informant's Na	me/Relations	hip <i>(Type</i> ,	Print)		==1	19b. Maili	na Address	(Street a	nd Numbe	er or Rui	al Route Numi	her City	or Town	State Zin	Code	
Mg 2 nd 2 allth a 27 la	1		O.C.M.E	•										nore, M					
Battimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours elf appartment of Health and Mental Hygiane. Appartment of Health and Mental Hygiane. Appartment if I tem 27 is marked other than "natural", or my injury or other traumatic avant, the Medical Examination.		20	a. Method of Disp 1 Burial 2 C 4 Donation	Cremation			State	20b. Pla	ce of Disponentary, cre	sition (Nan	ne of			Date			City or To		
Baltimol permit. Pages Dapartment of Important: If is	i ki	2	1. agricultus of Fur Re	neral Service	Licenses	the hos	Pec	tor	200	Name an tate altin	d Addres Anat lore,	s of Facilit) 2120	d 655 W	7. В	altin	nore S	Stree	t
8760, sate be executed mysicien and the burial-transit		uı	equentially list con a y, bearing to an use. Enter Under ause (Disease or i at initiated events sulting in death) L		b c	Due to (or as a co	untaque	stied of):										
.O. Box 687 the death certificate by the attending phy: ached for use as the	Physician/Medic		FEMALE: 8b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?		lf yes, outd 1∐Live bi 4∐Pregna 9∐Unkno	irth 2.⊡ ant at time	Fetal d	leath 3[Ectopic pro						23d. Dat Mo	e of deliver	y Day	Year
cords, P w requires that been signed t should be det	و		rt II. Other signific Cirrhosis								ause give	n in Part I.					ibute to the		death? Unknown
	Completed													24a. Was auto perfo 124 Yes	psy ormed?	P	Vere autoportor to com	pletion of	s available cause of
of Vital Physician: 1 rithis certificel ral director, p	Be	25	. Was case referre examiner?		Hosp	ital:					le.		of Deat	n Check only	-		<u> </u>		
Phys This	5	27	M☐ Yes 2☐ N Manner of Death	10		الكرا	patient		R/Outpatier			7 🗆 1101		me 5 ☐ Resi)	
ding I h. After funer	Certification;	-	1 XNatural 2 Accident	5 Pendin		8a. Date o (Monti	h, Day Ye	ear)	8b. Time of Injury	м 2	Bc. Injury Work	at ? es 2∐1		28d. Describe	how inju	ury occurr	ed		
VISION Attanding r death. actor: After	flca		3 Suicide	6 Could r	ot be	Be. Place	of Injury -	- At hom	e, larm, str					28f. Location (Street a	and Mumbe	er or Ruml	Pouta Mus	- hor
DIV.	Fr		4 Homicide	deteim	ned	buildin	g, elc. (S	Specify)		oot, ractory,	omoo			City or To	wn, Stat	te)	or murar	modite ivan	nuer,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical C	29	(Check only one)	1 ☐ Certifyin 2 ☑ Medical I	-Adminitel.	n: To the On the ba and mann	SIS OF 6X9	aminatio	edge, death n and/or in	occurred a restigation,	it the time	e, date and nion, deat	d place, h occurr	and due to the ed at the time,	cause(: date ar	s) and mai nd place, a	nner as sta	ited. the cause((s)
To th withir To th comp	Me	29	b. Signature and ti	itle of certifier	RN	1 -	0 (2011		29c.	License	number ME					(Month, D		 05
		30	Name and address	ss of person	vho-eomple	eted cause	of death	(Item 2	3a) (Type ₁	Print) D		hue		-1.					
		L	Jasha	Zav	eent	ez	M	0	1	TT Le	nn S	reet	: B	altimor	e, I	Maryl	and 2	21201	
S Regis	tate trar	31	Date filed (Month	EP 2 9	2005	32. Re	gistrar's	Signatur		2000									
riegis		L	3	LIGO	2005	1 820	Tens-	18	6										

			For	State of M	aryland /	•			Mental Hyg	iene	
_			1 - Stata Registrar 1. Decedent's Name (First, Mid	Idle. Last)		Certifi	cate of D	Death	2 Date of Deat	ng. 16. U U J	3 1582
	Physicia /Medic		ODELL	WILLIAM	18				Septem	ber 23 2	pos 9:55 am
	Examin		4a. Facility Name (If not institut	4 t A /		4b.	City, Town, or I	Location of Death	1	4c. County of E	Death
H	Funeral	-	5. Sociaf Security Number	6. Sex 7. Ag	ge (In yrs. last		Jnder 1 Year	If Under 24 Hrs.	8. Date of Birth	Vest) 9.	Birthplace (State or Foreign Country)
	Director		219-74-0770 Usual Residence of Decedent	1 M 2□F	46	Yrs.	nths Days	Hours Min.	DEC. 13		MARYLAND
	yland		10a. State 10b. Coun	ty	10c. City, To	own or Locatio	n			2	10d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	Director	MARYLAND	NIA			Of. Zip Code	LTIM		Og. Citizen of Wha	1/2 Yes 2 No
	May with 1		10e. Street and Number	FRANKI	11/537	REET	or. Zip Code	2120	0/		SA:
	er deat	Funeral	11. Marital Status	12, Was Decedent Armed Forces	Ever in U.S.		Decedent of His , specify Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
220	hours after death with the Marylar turel', or items 23e or 28e-f show Execities must be notified at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorce	If Yes Give		101	res 2 No	Specify:		Specify:	BLACK
ה ה	"natural",	Completed	15. Deced (Specify only high	ent's Education hest grade completed)	16	6a. Decedent's	Usual Occupat	tion uring most of wor	king	16b. Kind of Busin	ess/Industry
7 7	f within jiene. r than	omp	Elementary/Secondary (0-12	,	5+)	III. DO N	AB0	_		500	A COMPANY
	be filectal Hyg	Be	17. Father's Name (First, Middle		1			18. Mother's Nan	ne (First, Middle, M		(-
Z	hould id Men marke matic	ဥ	19a. Informant's Name/Relatio	nship (Type, Print)		/ A M. 19b. Mailing Ad		LV /	ral Route Number	JUR City or Town, Sta	NGR te, Zip Code)
Ĭ.	and 2 saith ar		ARTHUR WILL	IAMS (BRO)	. \	4820		BORNE		ALTO,	10, 21229
ore	it of He it of He if itan or oth			n 3 Removal from State	ceme		y or other place	' 1 -	~	20c. Location - City	
	nit. Pa partmer ortant: injury e.		* 4 □ Donation 5 □ Other 21. Signature of Funeral Service		ME7	RO C/ 22. Na	REMATO	ORY. 09-	28705	JR. FUN	YORE, MD.
n n	permi Depa Impo any ii		P()	(). 100	m	アゴ	140 N	H FULTO	ON AVE	BALTO	MD 21217
			23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final	ist only one cause on each f	line.		W				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ACOUL	a consequent	ce of):	U_)	Syndi		addien
	Examiner	_	Sequentially list conditions,	b. Methy	ulle		teent St	aple all	neus Ba	clereuu	a approx I wh
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S Due to (or as	a consequenc	ce or):		U			
Ď	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequenc	ce of):					
08/pn	0 8	edical		d							
XOD	he death certifical r the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			opic pregnancy			23d. Date of Month	delivery Day Year
	he death or the atten	yslcl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of death	n 5⊡ Oth	er (specify)			Month	Day rear
λ, T	v requires that the de been signed by the should be detached	by Ph	Part II. Other significant cond						23e. Did tob	pacco use contribu	te to the cause of death?
cords	w require been sign should t		<u> </u>	ge reual d	muse		1000		1 □ Y€		Probably 4 Unknown
Lec	The law ate has b page 2 sf	ompleted	<u>auu sia</u>	ge renal a	recep	e, m	sialy 8	15	24a. Was a autops perform	y prior ned? deat	
Vital	sician: The lav certificate has irector, page 2	Be Co	25. Was case referred to medi examiner?					26. Place of Dea	1 Yes 2 uth (Check only on	e) 1	Yes 2□ No
01 <	Phys this ral di	우	1 Yes 2 No	Hospital: 1 Inpati		Outpatient 3	DOA Other	4 Li Nuising F		ance 6 Other (Specify)
	Attanding Is death.	atlon	1 Natural 5 ☐ Pen	(Month D	ay Year)	Injury	28c. Injury Work' 1 🗆 Y	? es 2 □ No	200.000		
UIVISION	or Atta fter de Sirecto in by th	ertification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rmined 286. Place of In	njury - At home ntc. (Specify)	, farm, street, f	actory, office		28f. Location (St City or Town		r Rural Route Number,
_	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	O	29a. Certifier 1 Certif	ying Physician: To the best	t of my knowler	dge, death occ	urred at the time	e, date and place	, and due to the ca	ause(s) and manne	or as stated.
	To the Hos within 24 h To tha Fun completely	Medical	one)	al Examiner: On the basis of and manner st	tated.						
	Wit To	-	29b. Signature and title of certi	on who completed cause of a the thin, M	Minic	icon	DS (399		Sent. 2	3,2005
	2		30. Name and address of pers	on who completed cause of	death (Item 23	Sa) (Type, Print) 0- 1	ca D.	11600	712	01
			: 31. Date filed (Month, DavYe	EXLLAN, M	rar's Signature	SUL 8	i. raw l	XI. 150	unun	e UZ	~!
	Sta Registi		31. Date filed (Month, Day, Ye SEP 2 9	2005 Received	S. A						

			1 - For Stete Registrar	State of	f Marylan	id / Depa	artmen rtificate	t of He	ealth a	and M	ental Hy	giene Reg. No.	00	5	316	83
3.	Physici	an	1. Decedent's Name (First, Middle,	•							2. Date of De Month		, Y	ear	3. Time of	
	/Medic	_			arry La	mbert					Septem	-			3:25	РМ
	Examin	ner	4a. Facility Name (If not institution, g Holy Cross Hos		n <i>ber)</i>		4b. City, Silv						County of Montg		·V	
	uneral	10 V m			7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	th		. Birthol	ace (State o	r Foreign
	Director		236-05-9648	1 🔀 M 2 🗆 F	91	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept 2	7, 1	.913 V	Vest	Virgi	nia
and	*		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10	d. Inside Cit	ty Limits
Mary	feto	to	MD Prince	George	La	urel									1 XYes	2 🗆 No
h the	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of Wh	at Count	ry?	
.UU36 hours after death with the Maryland	ital Hygiene. id other then "natural", or liems 23s or 28s-f ehow event, ilie Mudical Examiner mast be notified at		501 Main Stree	t			20	707				U.S				
er de	ltems Der E	Funerai	11. Marital Status	Armed Fo		.S. 13.	Was Deced If Yes, spec	lent of His ofly Cubar	spanic Or n, Mexicai	rigin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	D-	14. Race - Black,	America White, e		
JSD Irs aft	o la	by F	1 ☐ Never Married 2 ☐ Marner 3 【X Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ates:		1□ Yes	21X No	Specify:	:			Specify:	Whit	е	
Vithin 72 hours at	natura lical E	sted	15. Decedent's (Specify only highest	Education		(Give	dent's Usua kind of wo	de done di	urina mas	st of workii	na		ind of Busi			
CLZL:	hen "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	inist	e retired)	,		.3	Va	cht b		orc	
B	other t	e Co	6 17. Father's Name (First, Middle, La	est)		Macii	Inist		18. Moth	er's Name	(First, Middle			ullu	.EIS	
Maryland 2	ked o	To Be	Frank Walker								Jessi					
ary shou	of Health and Mental F Item 27 le marked ot r other traumatic ever	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Numb	er or Rura	l Route Numb	er, City o	r Town, St	ate, Zip	Code)	
	m 27 l	١.,	Terry Lee Walk	er /son			-		oad #		Jessu		-4			
Baltimore,	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐Removal from	State	Place of Dispo cemetery, crea	matory or o	ther place			ate		ocation - Ci			
E Pa	rtant: njury		4 Donation 5 Other (Special Signature of Funeral Service of	/ 1	W.	Arunde		-					nton,	Mar	yland	
Balt	Department of the function of		21. Signature of Pulleral Service Es	1000	M001	60	Donal	dson	Fune	eral ve. T	Home, aurel,	P.A.	vland	207	07-43	89
2			29a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that c	aused the deat								, Land	20,	Approximate Interval Bety	9
Ph	ysician		Immediate Cause (Final disease or condition	•	acrania	1 Hemm	orrha	αe							Onset and D	
/ ; _ /N	Medical aminer		resulting in death)	_ a	or as a conseq			<u> </u>								
EX	annier	<u>_</u>	Sequentially list conditions,		onary E											
fed b	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Y	tate Ca											
у,	ial-tra	Examine	that initiated events resulting in death) Last	C	or as a conseq											
8 / 60 ate be e	physicien and the burial-transit	dicat	,	d. Conge	estive	Heart	Failu	re								
£ 0	ding pl	/Med	IF FEMALE:	23c. If yes, out	come of progn	2001										
Box Bath cer	led by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 ☐ Feta ant at time of c	I death 3[☐Ectopic pr ☐ Other (sp					1	23d. Date of Month		-	ear ear
) eg	by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unkno												
S, P	E 0	by P	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying c	ause give	n in Part I	I.	23 e. Did	tobacco u	ise contrib	ute to the	e cause of de	eath?
order.	been signated by should b										10	Yes 2	□No 3	Proba	ıbly 4. XXV	inknown
VITAL RECOLDS, sician: The law requires t	has be e 2 sh	Completed									24a. Was	DSV	pric	or to com	sy findings a apletion of ca	available ause of
	certificate has t irector, page 2 s										perfe 1 ☐ Yes		1	th? Yes	2[X No	
VICIA	iis certii directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1/XII	npatient 2	ER/Outpatier	nt 3 DC	Othe	·~		ne 5□Res		6 □Other	(Canalti	1	
VISION Of VITA Attending Physician:	5 €	 	27. Manner of Death		of Injury	28b. Time o		8c. Injury Work			28d. Describe					
ondin	death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investiga	tion	, 22, 7, 32,7	,,	М		es 2	No No						
DIVISION I or Attending		Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place	of Injury - At hing, etc. (Specif	ome, farm, st fy)	reet, factory	r, office		4	28f. Location (City or To			or Aural	Route Numi	ber,
Hospital or	erel Filled		29a. Certifier 1 ACertifying	Physicien: To the	best of my kno	teah anhalwo	h occurred	at the tim	e date ar	nd place, a	and due to the	Cause(s)	and mann	or ac et	nted .	
e Hos	24 hours after 6 Funerel Dire	edical	(Check only 2 Medical E.	ceminer: On the ba	asis of examina ner stated.	ation and/or in	vestigation	in my op	inion, dea	ath occurre	ed at the time,	date and	place, and	d due to	the cause(s))
To the	within 2 To the complet	Me	29b. Signature and title of certifier				290	. License	number			29d. Dat	e signed (Month, E	ay, Year)	
			> molar	ull	, , M.	D.		D006	2520			Sep.	tembe	r 22	200	5
	12		30. Name and address of person w Maria Darbela,	no completed caus	se of death (Iter 500 For	n 23a)(Type, est Gl	Print) .en Ro	ad,	Silve	er Sp	ring,	MD 2	0901			
	Sta		31. Date filed (Month, Day, Year)		gištrar's Signa		1 4			-				-		
20	Regist	rar	SEP 2 9	2005	Mad case	15 18	08462	7								

Eno Worthy, Jr.

N.			1 - For State Registrar	of Maryland		rtment of Ho			iene 005	31684
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Septemb		3. Time of Death 23:06 M
	/Medic	al	Eno 4a. Facility Name (If not institution, give street and		Worth	y, Jr. 4b. City, Town, or	Location of Death	septem	4c. County of D	
	Examin	er	Prince George's Hospital			Chever1			Prince (
	Funeral Director		5. Social Security Number 6. Sex 133-64-5953	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 26,	9. I 1982 Ne	Birthplace (State or Foreign Country) W York
			Usual Residence of Decedent					114 20,	1702 110	
	death with the Maryland ms 23a or 28a-f ehow	_	10a. State 10b. County		Town or Los					10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	ith the Marylar or 28a-f ehow	Directo	Maryland Prince George	's Temp	le Hi	10f. Zip Code		11	0g. Citizen of What	
	23a or	i	3378 Curtis Drive			20748			U.S.A.	
	death	Funerai	11 Marital Status 12. Was D	ecedent Ever in U.S. I Forces?	. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp.	ecify Yes or No- Rican, etc.)		merican Indian, /hite. etc.
ရွ	s after des , or items	by Fu	1 Never Married 2 Married 1 ☐ Ye	es 2 No Give or Dates:	-	☐ Yes 2∑ No	Specify:		Specify:	
315-0036	J within 72 hours after death with the Maryla jiene. Then "natural", or items 23e or 28e1 ehov Itte Mudical Examiner must be notified at		15. Decedent's Education		16a. Deced	ent's Usual Occupa	tion		16b. Kind of Busine	Black ss/Industry
2	hin 72 9. Pn "ne	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired)	uring most of work	ing		
7	filed wit Hygiene other the	Соп	12		L	aborer	18. Mother's Name	- (Circh Adiabata A	Constru	ction
yland	d tal	Be c	17. Father's Name (First, Middle, Last) Eno Simon				Angela V		valden Surname)	
_	2 should and Men ie marke aumatic	To	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a			City or Town, State	e, Zip Code)
, Ma	nd 2 lith a 27 is r tra		Janet Fenner (Grandmot			arkspur L		-		
ore	ges 1 a t of Hee if item or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal fro			sition (Name of natory or other place			20c. Location - City Farmingda	
Baltimore,	permit. Pages Depertment of I Importent: if it eny Injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	St.	-	es Cemete	-			ite, Ni
n	Depending of the popular opposite of the popular opposite		Dennie Otal	mon		Name and Addres Roy L. Gi 191–02 Li	lmoré Fui nden Blvo	neral Ho 1., St	me Albans, N	Y 11412
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death.			-			Approximate Interval Between
) :	Physician		Immediate Cause (Final disease or condition resulting in death)	ab wou	rels	D) well	and 1	Mila	T	Onset and Death
	/Medical Examiner		Due Due	to (or as a conseque	ence of):	/				
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conseque	ence of):					
/	deeth certificate be executed e ettending physiclen and nd for use as the burial-transit	Examiner	that initiated events	to (or as a conseque	ence of):					
3/60,	siclen burial	Ilcal E		10 (0) 40 4 001100440	3.100 017.					
Õ	tificate ng phy: as the		0.							
ROX	eeth certifi ettending I for use as	an/N	in the past 12 months?	outcome of pregnance ve birth 2 Tetal d	death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
o.	at the dee by the e tached fo	Physician/Me	1 Type 2 TNo 4 Pri	regnant at time of dea nknown	ath 5∟	Other (specify)				
T	law requires thet the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to	o death but not result	ting in the ur	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute	e to the cause of death?
ecords,	w require been sig should b							1 □ Ye	es 2.DoNo 3□	Probably 4 Unknown
Hec	The law r ste has be pege 2 sh	Completed						24a. Was a autops perform	y prior ned? death	
Vitai		0	25. Was case referred to medical				26. Place of Deat	1 X Yes 2		(es 2□ No
<u>=</u>	Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 □XE	:P/Outpatien	t 3 DOA Othe	4 Nursing Ho	me 5 Reside	ence 6 Other (S	Specify)
n o	ding Ph h. After th funeral		1 □Natural 5 □ Pending (A	Annth Day Vearl	28b. Time of Injury	Work	at ? ∕es 2.1⊠No	28d. Describe ho	w injury occurred	abhed
Division	or Attending Physicien: uter death. Director: Atter this certific in by the funeral director,	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	lace of Injury - At hom	2-2:04		95 2 LQ110	28f. Location (St.	reet and Number or	Rur I Route Number
2	ei or s s efter st Dire	Certification:	4 Homicide determined bu	uilding, etc. (Specify)	rkin	1-1-		Tempular	Hills 47	Curtis D
	To the Hospitel or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Exeminer: On the and medical Exeminer.)	e, date and place, inion, death occur	and due to the cared at the time, da	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title certifer			29c. License			9d. Date signed (Me	
	Λ		1/1/h	21PPLE,	br	0.0	C.M.E.	1	September	22, 2005
	'\		30. Name and andress of person who completed of	ause of death (Item)			ot Bolt	imoro M	Maryland 2	21 201
	Sta	te	Susan R. Hogan, M.D. 31. Date filed (Month, Day, Year)	. Registrar's Signatu	-	Term Stre	et, Dall	THOLE, I	LLYLAIU 2	11401
	Regist		SEP 2 9 2005	2. Hegistrar's Signatu	Spa	15cm				

State of Maryland / Department of Health and Mental Hygiene, 1 - Stete Registrer 31685 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ALLEN WILSON 09.22. 7:30 *20*05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ALEXANDER AVENUE CATONSVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F 69 241.50.5413 NC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Modical Examiner runt be notified at 1 ☐ Yes 2 🔀 No BALTIMORE CATONSVILLE Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ALEXANDER 1104 AVENUE 21228 or items 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) PSYCHIATRIC AMENDANT STATE 12 TH GRADE 12 should be filed with and Mental Hygien 7 Is marked other th NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HARVEY WILSON CORNELIA EVANIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 is WIFE 1104 ALEXANDER AVE. CATONSVILLE MO MARIAN WILSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Sign ture of Funeral service Licensee 09.28.05 BALTO. MD GREENMOUNT 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD. NATT PIKE, BAUD. MD 21229 m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons Juence of): Examine Em. L Due to or a a consequence of) resulting in death) Last Box 68760, attending physician 99 Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 🗌 Yes 2 No 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funeral Direct 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 300 Armory 40 31. Date filed (Month, Day, Year) 3 Registrar's Signature 2 9 SEP 2005 Registrar

		•	For State Registrar	State of M	aryland / Depa	artment of H			2005	31686
	Physicia	an	1. Decedent's Name (First, Middle	Last)	WRIGHT			Date of Death Month	Day Year 23 200	3. Time of Death 5. 7:00P M
>	/Medic Examin		4a. Facility Name (If not institution,	, , ,		4b. City, Town, or	Location of Death	rienden.	4c. County of Dea	
	Funeral		7907 LASAU 5. Social Security Number 7.14.18.18.28	7.00.	ge (Injyrs last birthday) Yrs.	If Under 1 Year Months Days	AUTIMOKE If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Y	9. Bi	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town fr Lo	ocation	I. IY	ARCH 12	PUU	10d. Inside City Limits
	ter death with the Marylar Items 23a or 28a-f show Increment be notified at	ctor	MD		BA	TIMORE	,			1 Yes 2 No
	th with th	al Dire	4909 LASAL	LE AVE.		10f. Zip Code	21200	10g	Citizen of What C	
036	g o B	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ied 1 Tyes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Speci an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	72 na na	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of working		b. Kind of Business	
	filed within Hygiene. Ither than "		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, I	College (1-4or	CORRE	chowar	OFFICE:			- MARYLAND
Maryland	be d la la la la la la la la la la la la la	To Be	CLARENCE	WKIGHT			ELS	IE V	JOHNSO,	
Mar	and 2 should ealth and Mer m 27 is marke her traumatic		19a. Informant's Name/Relationsh MELISA O. WK	hip (Type, Print) IGHT (WI+	- 1	•	and Number or Rural F	4		Zip Code) ARYLAND 21266
nore	of H of H if ite		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		20b. Place of Dispo cemetery, cres	matory or other plac			c. Location - City o	TOWN, State
Baltimore	permit. Pag Department Important: any injury o		21. Signature of Funeral Service I				ss of Facility VAU	GHW C.	GREENE	FENERAL HM
	40200		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each i	d the death. Do not entine.	ter the mode of dyin			E MARYL	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Duesto for as	phoma a consequence of):					Onset and Death Zyears
	Examiner	10	Sequentially list conditions,	b. Due to list as	Es cunsuquence ut)					
<u>k</u>	s be executed sician and burial-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с						
,092	death certificate be executed e attending physician and nd for use as the burial-transit	ical E	rooting in county back	d	s a consequence of):					
89	eath certifica attending ph I for use as th	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	alivery
O. Box		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Ectopic pregnancy Other (specify)			Month	Day Year
α.	es the	þ	Part II. Other significant condition	» contributing to death t	out not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobac		to the cause of death?
Records,	aw requir s been si 2 should	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
al Re			OF Manager referred to medical				00 Plant (Part) (performe 1 ☐ Yes 2 €	d? death? No 1 □ Ye	
f Vital	is di	To Be	25. Was case referred to medical examiner? 1 Yes No	Hospitali	ent 2 ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing Home	92	ce 6 □Other (Spe	ecify)
on of	ting After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investig		ury 28b. Time o Injury	Wor	y at 28/ k? Yes 2 □ No	d. Describe how	injury occurred	
Division	if or Attending after death. Director: After In by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of In	jury - At home, farm, str tc. (Specify)	reet, factory, office	28	f. Location (Stree City or Town,		Rural Route Number,
-	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical C		g Physician: To the best Examiner: On the basis of and manner st	of examination and/or in		ninian, doath convered	at the time, date	and alone and du	a to the equac(c)
	To the Comple	Me	29b. Signature and title of certifier	JF (1	mbill	10 DOD	e number 73887	29d	Date signed (Mor plember 2 MD	ith, Day, Year)
	13		30. Name and address of person	who completed cause of	death (Item 23a) (Type,		7000	Je,	117	
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	ROADWA	AY BALT	114026	, NID	
	Registi		SEP 2 9 2	2005	J. Sp	wei				

			Pleas	se Type or Pri	nt in Black II aryland / Dep				•	
			1 - For State Registrar	State of Mi		ertificate of			9. No 2 0 0 5	31687
	Physici /Medic		Deborah A. Wo					2. Date of Death Month	Day 7 Year	3 Time of Death
	Examir		4a. Facility Name (If not institution, Baltimore/Washi	_	al Center	4b. City, Town, c	r Location of Death		4c. County of Dea Anne Ar	
	Funeral Director		5. Social Security Number 220-64-3571	6. Sex 7. Ag	e (In yrs. last birthda 42 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 22,	Year) 9. Bir 1963 Mar	thplace (State or Foreign buntry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f aho	tor	Maryland Anne A	rundel	Glen Bu	rnie				1 ☐ Yes 2X No
	th with the 23a or 28	Funeral Director	10e. Street and Number 468 Norvelle Co	ourt		10f. Zip Code	21061	10	og. Citizen of What Co United St	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow or other traumatic event, the Medical Examinational be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ed 1 Tyes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 💆 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	"natur	Completed	15. Decedent' (Specify only highest	s Education t grade completed)	(Giv	edenl's Usual Occup re kind of work done DO NOT use retire	during most of work	ring	6b. Kind of Business	Industry
212	filed withir Hygiene. other than	omp	Elementary/Secondary (0-12) 12	College (1-4or !	(+)			uperviso	r Medical	Billing
nd 2	al Hyg	BeC	17. Father's Name (First, Middle, L					e (First, Middle, M		
yla	should be nd Mental marked o	10	Robert E. Hoff	·	10h Ma	ling Address (Street		Gauger	City or Town, State, 2	Zin Codo)
	and 2 sho ealth and n 27 is ma		Matthew S. Wood						e, Marylan	
Baltimore,	of Health of Health if Item 27 or other tra		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from State		ematory or other pla	ce)		20c. Location - City or	
Itim	permit. Pages Department of t Important: If Its any Injury or or once.		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Pineral Service).	ecify)		ill Cemete	_			ark, Marylan
Ba	Depa Impo any I		21. Signature il Mileral Service	1 Bink	ًا ر				neral Home more, Marv	, Inc. land 21229
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in dealh)	-a. Met.	the death. Do not e		ng, such as cardiac			Approximate Interval Between Onsel and Death
0, ^	Examiner be executed by sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Deer to (or as	a consequence of):					
9289	cate be physicia the buri		1	d						
O. Box	that the death certificate be executed led by the attending physician and detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Û No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	1		23d. Date of del Month	ivery Day Year
ds, P	uires that n signed b ld be deta	þ	Part II, Dther significant condition	ns contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		acco use contribute to s 2 □ No 3 □ Pr	. /
Il Record	: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nl 2 ☐ ER/Outpati	ent 3 DOA Oth	or•	h (Check only one	nce 6 Other (Spe	264
of	ding After fune	tion: To	27. Man or of Death 1 Natural 5 Pending 2 Accident investig.	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injur		28d. Describe how		ony)
Division	i Diffe	Certification:	3 Suicide 6 Could n 4 Homicide determin		ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best Examiner: On the basis o and manner st	examination and/or	ith schamed at the line investigation, in my d	no date and stans pinion, death occur	and due to the nai red at the time, da	te and place, and due	stated to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	E. Wri	h Mr	1D, 29c. Licens		29 S.	d. Date signed (Monti	27, 2005
	10		30-Name and address of person v	who completed cause of d	eath (Item 23a) (Type D, 3() H	Depital D	rive, Gl.	en Bur	nie, MD.	21061
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 20	M32. Hegistr	ar's Signature	W				

			1 - State Registrar		partment of Health and I Certificate of Death	Mental Hygier		31688
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		Ruby. C. W.	11		A 22	26 2005	4:451.M
	Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death		c. County of Death	
			NORTH ARUNDAL	HOSP, TAL	Glen BURNIE		ANNE A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Months Days Hours Min.	(Month, Day, Yea	9. Birthi	place (State or Foreign ntry)
	Director		215-59-6851 TLIM 3DU Usual Residence of Decedent	00	*	July 11,1	917	TA.
	/land	1	10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits
	Man a-f sh ified	to	MD HARFORD	HA	VLDE GLACE			1 ☐ Yes 2 No
	with the Maryland a or 28a-f show	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Cou	
	23a c	ai	101 WID GEON.	DR.	21078		0 5.	H .
	tems 23	Funeral	Ame	d Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	ours after death with the Marylan rel', or Items 23a or 28a-f show Exertirer must be notified at	by F	If Yes	es 2 No . Give or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
5-0036	72 hours after "neturel", or Ite		15. Decedent's Education	16a. De	ecedent's Usual Occupation	16b.	Kind of Business/In	dustry
215	nin "n	Completed	(Specify only highest grade comple Elementary/Secondary (0-12) Colle		live kind of work done during most of wor e. DO NOT use retired)	king		
2121	ill Hygiene. Other than rent, I're M	E O		(6	Homemaker		Home.	
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	en Sumame)	
yla	2 should be and Menta Is marked sumatic ev	၉	JAMES GOMER			e Bell		
Maryland	12 sho		19a. Informant's Name/Relationship (Type, Print,	, ,	ailing Address (Street and Number or Ru WibG eoル DL , t			
	os 1 and of Health item 27		DANIEL SEU 20a, Method of Disposition	20b. Place of Di	sposition (Name of		Location - City or To	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "netur any injury or other traumatic event, If a Madical any injury or other traumatic		1 Burial 2 ☐ Cremation 3 ☐ Removal f	rom State cemetery, o		0105 L	21/010 1	MΛ
ij	permit. Page Department of Importent: If any injury or phos.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	KESI	22. Name and Address of Facility	-110 Ginera	1 HD 24 CI	47D:
Ba	permit. Departr Importe any inji		Vaul M. St	tela	22. Name and Address of Facility ST HARTIEY Miller - ST 2527 has GRO PO.	3.0 lto. No	21234	
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. Do not on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	med Ancie	beaut La line			Onset and Death
	/Medical		resulting in death)	to (or as a consequence of):		1	V .	
п	Examiner	_	Sequentially list conditions, b.	enosclinte	Cavalia mentin	wait a	white	
V	ed	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):				
V	executed in and ial-transit	Examiner	that initiated events c	to (or as a consequence of):				
8760,	cate be executed physicien and s the burial-transit	<u>a</u>						
9	tificat ig phy as th	ledic						
Вох	death certific e attending p ed for use as	an/N	23b. was decedent pregnant	, outcome of pregnancy ive birth 2 Petal death	3 □Ectopic pregnancy		23d. Date of delive	*
	0 0 0	Physician/Me	1 Yes 2 No	regnant at time of death	5 Other (specify)		Month	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown Part II. Other significant conditions contributing	to death but not resulting in th	e underlying cause given in Part I	23e. Did tobacco	o use contribute to t	he cause of death?
ds,	S	d by	Faith. Other signmount conditions contributing	to death but not resulting at the	o underlying cause given in trait.		2 No 3 Prot	
Records,	> 0 %	Completed				24a. Was an	24h Ware auto	opsy findings available
Rec	e la has	ф				autopsy performed?	prior to co death?	impletion of cause of
<u>ra</u>	icien: Th certificate rector, pag	e Cc	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 XN ath (Check only one)	Vo 1 ☐ Yes	2 No
of Vital		0 B	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpa	Othor	ome 5 Residence	6 ☐ Other (Specif	(y)
10 ر	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 Natural 5 □ Pending 28a. C	vate of Injury Month, Day Year) 28b. Time		28d. Describe how in	jury occurred	
Sio	Attending ir death. ector: After by the fune	atic	2 Accident investigation		M 1 Yes 2 No			
Division	or Att	Certification:	dotorminad 289.	lace of Injury - At home, farm, uilding, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta		al Route Number,
	pitel ours a eral [Ce	29a. Certifier 1 Certifying Physician: T	the hest of my knowledge d	eath occurred at the time, date and place	and due to the cause	(s) and manner as s	tated
	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On t		r investigation, in my opinion, death occu			
	To the within To the complete	Me	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month,	Day, Year)
			ABOVE	MO	D 43977	Sel	Ember 20	, 2005
	10		30 Name and address of person who completed	cause of death (Item 23a) (Ty	pe, Print)	10 - 0	2 thl 1	
	1	to	31. Date filed (Month, Day, Year)	2. Registrar's Signature	we won shine	1040	C1001.	
	Sta Registr	_	SEP 2 9 2005	lower It A				
			<i>L</i>					

		1 - State of State of Registrar		artment of Health and N <i>rtificate of Death</i>	Mental Hygie Reg.		
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Isabella J.	Wadkins		2. Date of Death	2005 6 ^{ay} 2005	3. Time of Death (
Examine		4a. Facility Name (If not institution, give street and numb 4102 Taylor Ave.	er)	4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimor	e
Funeral Director		219-32-3907 ^{1□M 2⊠F}	Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 6,	9. Birthp 1936 Vir	lace (State or Foreign try) ginia
Maryland -f show led at	tor	Usual Residence of Decedent	10c. City, Town or Lo	cation Baltimore		11	0d. Inside City Limits 1 ☐ Yes 2 █No
h with the	Funeral Director	10e. Street and Number 4102 Taylor Ave.		10f. Zip Code 21236		Citizen of What Coun	try?
I's	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give	₩ 0	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - America Black, White, 6 Specify: Whi	etc.
within 72 ho ane. than "netur he Medical i	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) S C	king	Nursing	lustry
be filed tal Hygie d other event, II	Be Co	6th 17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai	*	
should to nd Ment marked matic e	၉	Ephriam sayers 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	Fran		refield	Code)
and 2 seath ar m 27 is		Doris Burke /daughter	704	Sterling Ave.	Baltimon	re MD 212	220
Pages 1 ment of H ent: if ites lury or oth		20a. Method of Disposition 1 □ SBurial 2 □ Cremation 3 □ Removal from Sta '4 □ Donation 5 □ Other (Specify)	HollyHi	illCemetery 9/3	30/05 I	Baltimore	MD
permit. Depart Import any inj		21. Signature of Funeral Service Licensee	elly	2. Name and Address of Facility Co 300 Mace Ave.	Baltimo	re MD 21:	
Physician /Medical Examiner				er the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
	al Examiner	Cause (Disease or injury that initiated events c.	as a consequence of): as a consequence of):				
± ந்க் .	Physician/Medical		n 2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
w requires that been signed by should be deta	۵	Part II. Other significant conditions contributing to deat		nderlying cause given in Part I. RTERY DISEASE		co use contribute to the	e cause of death?
: The law recate has bee	Completed				24a. Was an autopsy performed 1 Yes 2 📆	? prior to com death?	sy findings available apletion of cause of
ysicien: The is certificate director, pag	o Re	25. Was case referred to medical examiner? 1 Yes	atient 2 ER/Outpatien	Other	h (Check only one)	6 □Other (Specify)	
£ 5 1	-	27. Manner of Death 1 Matural 5 Pending (Month, 2 Accident investigation			28d. Describe how in		
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funers	Certification;		Injury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
he Hospi n 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the beside and manner. 1 Medical Examiner: On the basis and manner.	s of examination and/or inv	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as sta and place, and due to t	ted. the cause(s)
With To t	Σ	29b. Signature and title of certifier	12 a M.T	29c. License number	29d. I	Date signed (Month, D $7 - 28 - 0$	ay, Year)
1		30, Name and address of person who completed gause of Siu ASAi UAM, Suite	of death (Item 23a) (Type, I	Print) ladelphia you	ol Mi	21236	/ 0 ·
State Registra			strar's Signature	DASS30 Print) Radefphier son		-	

05-6461 B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2005 MICHAEL WELDON 1 - For State Registrar 31690 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MICHAEL ALLEN WELDON 21, SEPT. 2005 4:32 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A UNIVERSITY HOSPITAL BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1007/2 33/1930 9. Birthplace (State or Foreign PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral 1**∕ M 2□ F 191-42-8923 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at HARRISBURG 1 ☐ Yes 2X No PA DAUPHIN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. BOX 60472 17106 USA Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Date¥J ETNAM 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry RESIDENTAL REAL College (1-4or 5+) YEARS nit. Pages 1 end 2 should be filed withir ertment of Health and Mental Hygiene. ortant; if item 27 is marked other then injury or other traumatic event, the Mi Elementary/Secondary (0-12) COMMERICAL ESTATE 12TH GRADE REAL ESTATE AGENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALLYN WELDON LEONA ROBINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MICHAEL COTTON/SON 108 SOPER LANE CAPITAL HEIGHTS, MD 20743 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CREMATION SOCIETY OF PA 9/28/05 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HARRISBURG, PA permit. Page Depertment o important; if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying; such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? ٥ 3 Probably 4 Unknown 1 🗌 Yes 21X/10 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No this certificete 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∑Yes 2 No Medical Certification: To 2X ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how jnjury occurred Declared 28c. Injury at Work? After Injury 1 Natural 5 Pending diver of vehicle wollden collision midrightm 1 Yes 2 No deeth. investigation 21-05 2 Accident s after deetl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 1-83 CA Belocust in by t 4 Homicide road To the Hospital o within 24 hours aft To the Funeral DI completely filled in Herford, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) OCME SEPT. 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Penn Street 0 Baltimore, Maryland 21201 .12. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

9 2005

						/ Department of	Health and Me	ental Hygien	² 005	31601
				State Registrar		Certificate o		Reg. N 2. Date of Death	o. 0 0 0	3 Time of Dooth
		Physici		1. Decedent's Name (First, Middle, Last) Charles Washington			C		ay Year	3. Time of Death
		/Medic Examin		la. Facility Name (If not institution, give street and n	umber)	4b. City, Town	, or Location of Death		c. County of Death	-
	н	Lxaiiii		Maryland Gener	a) How	sta Tha	timore C	ity		
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birth	hplace (State or Foreign untry)
		Director		081-18-5315 1∑M 2□F	81	Yrs.		pr 4, 192	4 Mary	land
5		and **		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
H		Mary f sho	ğ	MD	В	altimore				1∰Yes 2□No
Shing	,	death with the Maryland rms 23e or 28a-f show r must be routified at	Director	10e. Street and Number		10f. Zip Code	9	10g. C	itizen of What Co	untry?
. =		th with	ai D	1828 Madison Avenue 3rd	fl.r		21217		USA	
5		ems arms	ner		cedent Ever in U.S. Forces?	13. Was Decedent of	f Hispanîc Origin? (Specuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	ncan Indian,
0	36	n 72 hours after death with the Marylar "natural", or Items 23s or 28s-1 show edical Ever invermissible indiffical at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	i 2 □ No Rive	1 ☐ Yes 2 ☑ N				black
13	215-0036	hour tural	ed b	15. Decedent's Education	Dates: 146-5	16a. Decedent's Usual Occ	cupation	16b.	Kind of Business/I	Industry1
	5		Completed	(Specify only highest grade completed	1)	(Give kind of work do life. DO NOT use ret	ne during most of working	g		industry unk
	212		E	Elementary/Secondary (0-12) College	(1-4or 5+)	maintena	nce worker			
بة		be filed tal Hygi d other svsnt, I	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maide	n Sumame)	
()	<u> </u>		P	Linwood Washington		***	Netti	e Fitzger	ald	
2	Maryland	C1 60 = 65		19a. Informant's Name/Relationship (Type, Print) Joella Grant/sister		19b. Mailing Address (Stre 827 N. Arli				(ip Code) 21217
/)		s 1 and f Health itam 27 othar tr		20a. Method of Disposition	20b. Plac	e of Disposition (Name of	. Da		Location - City or	
\cup	Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☑ Other (Specify) in S	m State cem	etery, crematory or other p	place)		,	
	Ħ		þ.	21. Sign ture Funeral Service Licensee S Wardes,		22. Name and Add	dress of Facility Litomy Board	655 U. Da	1+1	Ctroot
	ã	permit. Departr Imports any inj		Jenan S, wade,	Virgitor	Baltimore	, MD 21201	w. Da	TCIMOLE	Street
				23a. Part 1. Ever the disease, or complications tha shock, or heart failure. List only one cause or	caused the death.	Do not enter the mode of o	lying, such as cardiac or	respiratory arrest,		Approximate Interval Between
		Physician	a. I	Immediate Cause (Final disease or condition	42100	ion Pre	ummia			Onset and Death
		/Medical		resulting in death)	o (or as a consequer		L 0 \			
		Examiner	L	Sequentially list conditions, b.	606557	ive Mear	1 taila	re		
		ted 1sit	Examiner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	2 (or as a consequer	distan	Aug 2) and a second	2:00	-
		be executed sician and burial-transit	xan	that initiated events c. resulting in death) Last Due t	o (or as a consequer	nce of):	Citor po	Herrock e	Curca	<u> </u>
	760,	ie be executed ysician and e burial-transii	cal	d	Hysect	00100				
	68	tificat ng phy as th		15551115						
	χοχ	th certendir	an/N		outcome of pregnancy birth 2 Petal de		ncy		23d. Date of deli	very Day Year
	O. E	the at	Physician/Med	1 Yes 2 No 9 Unknown	gnant at time of deat known	h 5 Other (specify)			10101111	Day Sai
	9.	fhat ff ed by detac	Ph	Part II. Other significant conditions contributing to	death but not resulting	ng in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
	ds,	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	d by					1 ☐ Yes	2□No 3□Pro	obably 4 Winknown
	õ	w req	iete					24a. Was an	24b. Were au	topsy findings available completion of cause of
	Re	The law te has l age 2 s	Completed					autopsy performed? 1 ☐ Yes 2 🗷 N	l death?	completion of cause of
	tal	sician: The la certificate ha irector, page 2	0	25. Was case referred to medical			26. Place of Death		0 12 100	
	\	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 No Hospital:	Inpatient 2□EF	VOutpatient 3☐ DOA	Other: 4 \(\sum \) Nursing Hom	e 5 Residence	6 □Other (Spec	cify)
	0 _	ng Pt		27. Manner of Death 1 28a. Dat 1 28natural 5 □ Pending (Mc	te of Injury onth, Day Year)	Injury V	Vork?	8d. Describe how inj	ury occurred	
	sio	tendi death. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	as of laives. At hom		☐ Yes 2 ☐ No	of Location (Street a	and Number or Pu	ral Route Number,
	Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	determined 200. Fig	Iding, etc. (Specify)	e, farm, street, factory, offic	,9	City or Town, Sta		rai Houte Holliber,
	_	spital nours neral / filled	aC	29a. Certifier (Check only (Ch	he best of my knowle	edge, death occurred at the	time, date and place, a	nd due to the cause(s) and manner as	stated.
		he Ho n 24 t he Fu pletely	edical	(Check only 2 Medical Exeminer: On the and ma	basis of examination	and/or investigation, in m	y opinion, death occurre	d at the time, date ar	nd place, and due	to the cause(s)
		To the To the Comp	Σ	29b. Signature and title of certifier	G	29c. Lice	ense number	29d. D	ate signed (Month	i, Day, Year)
				, Top Ow	204/	mis 8	べつうり	9	- 14-C	>5
				30. Name and address of person who completed ca	use of death (Item 2:	3a) (Type, Print)	Dacion	CTRARA	7 140	507.00
		C+-	ate	31. Date filed (Month, Day, Year) 32.	. Registrar's Signatur	9 6	· I wild wo	i Ochich		74.14.0
		Regist		SEP 2 9 2005	Margas A	a factor				

			. For	State of M							ental Hygi	iene -		
			1 - State Registrar				tificate					g. No. U U	15 (31692
	Physici	an	1. Decedent's Name (First, Middle,		т. т			-			2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,		ost, J	r.	4h City	Town or	Location o	if Death	Septemb	er 19		3:30 P. [™]
	Examin	er	St. Elizabet	•					more	Doam			/A	
	Funeral		,	3. Sex 7. A	ge (In yrs. last		If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,			ce (State or Foreign
	Director		219 12 3400 Usual Residence of Decedent	TLAKM ZLIF	85	Yrs.					Dec. 15	,1919	Mary.	land
yland	Mow at		10a. State 10b. County		10c. City, T	Town or Lo	cation						10d	I. Inside City Limits
e Mar	Sa-f e	ctor	Maryland Anne	Arundel	Li	nthic	cum							1 ☐ Yes 2 🛣 No
with fi	Pa or 2	Directo	10e. Street and Number 405 - S. Hami	mondo Forme	Pood		10f. Zip		.00		10	og. Citizen of W	hat Country	1?
death	ms 23	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. \	Was Deced	210 ent of His		in? (Spe	cify Yes or No-		- Americen	Indian.
-0036 hours after death with the Maryland	or Ite	/ Fur	1 XNever Married 2 ☐ Marrie	Armed Forces d 1 Tes 2 2 If Yes, Give			fYes,spec □Yes 2			, Puerto F	cify Yes or No- Rican, etc.)		White, etc	
21215-0036 d within 72 hours af	fal Hygiene. d other than "neturel", or Items 23a or 28a-f ehow event, Ita Medical Examinat must be notified at	ed by	3 Widowed 4 Divorced 15. Decedent's	Year or Dates									White	
C 1 2	n "ne Medic	plete	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	(5.1)	(Give life. L	lent's Usua kind of wor DO NOT us	i Occupa k done di e retired)	tion uring most	of workin	19	16b. Kind of Bus	iness/indus	stry
	at Hygiene. I other than " vent, the We	Completed	Elementary/Secondary (0°12)	4 year	5+)	Rece	ption	nist				St. Cha	rles (College
E 8		Be	17. Father's Name (First, Middle, L.	tave Yost,	Sr				_	rs Name Irene	(First, Middle, M Super)	
aryla should	and Menfa Is marked aumatic ev	은	19a. Informant's Name/Relationshi			19b. Mailin	a Address	(Street a			Route Number,		itate Zin Cr	nde)
	40 m	1	Irene A. Wilso		1		. Ham					nthicum		
ore	0 = =	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	I □Removal from State	COM.	e of Dispo	sition (Nam	e of her place)	Da		Oc. Location - C	•	
TIMOF F. Pages	Department of H Important: If ite any injury or ot once.		`4 ☐Donation 5 ☐ Other (Spe	cify)		r Hil	.1 Cen	neter				Baltimor		
Dermi	Depa Impo any ir		21. Signature of Funeral Service Li	censee	1/2						nce Fune			P.A. and 21225
			23a. an1. Enter the dise tre. r c	omplications that cause	ed the death. I								Ap	pproximate
Ph	nysician		Immediate Cause (Final disease or condition	. H M	e n	111	4							iterval Between inset and Death
	Medical xaminer		resulting in death)	Due to (or a	s a consequ <i>e</i> n									uning
		er	Sequentially list conditions,	b. Due to (or a	a consequen	ica oli.								
pejn.	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2										
/bu,	hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	s a consequen	ice of):								
	physic the bi	dicai		d										
X Seri	affending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d Date	of delivery	
. 0	ne affe ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pre Other (spe					Mont	,	y Year
hat the C	i signed by the a ld be defached f	Phy	9 ☐ Unknown Part II. Other significent condition		but not reculting	ag in the up	doth ion on		in Danil		220 Did tobe			
ecords, P.O.	signe Id be	d by	De me		g G	ig in the ur	derlying ca	use giver	ı ını rautı.		1 \(\text{Yes}	acco use contrib		y 4 Unknown
COLOS	s been si should I	oiete								-	24a. Was an		ere autoosv	findings available
r _e		Completed					·				autopsy perform 1 Yes 2	ed? de	ath?	findings available letion of cause of
VITAL ician:	director, pag	Be	25. Was case referred to medical examiner?	(11 - 11 -							Check onl one			3
P P	this aldii	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		Outpatient	3 DO	Other	4 Nur		e 5 🗌 Residen			
VISION	ifh. :: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Di	ay Year)	Injury	M	ic. Injury : Work? 1 🔲 Ye	a" es 2 □ N		d. Describe nov	v injury occurred	,	
UIVISION I or Attending	rector: A rby fhe fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place of in	jury - At home tc. (Specify)	, farm, stre	et, factory,	office		28	Bf. Location (Stre City or Town,	et and Number State)	or Rural Ro	oute Number.
pife ر	ores af		00.00									ŕ		
B Hos	within 24 hours affer death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best seminer: On the basis of and manner s	of examination	dge, death and/or inv	occurred a estigation.	it the time in my opi	, date and nion, death	l place, ar n occurred	nd due to the cau d at the time, dat	use(s) and mann e and place, and	ner as stated d due to the	d. e cause(s)
To th	within To th comp	Σ	29b. Signature and title of certifier	1/1/	- 1.			License				d. Date signed (
	2		• / /		MI	10	R	15.	27	46	J.	eft.	,21	,2005
	10		30. Name and address of person of Public Ray (Month, Day, Yar) SEP 2 9 200	no completed cause of	death (Item 23	(Type, F	Print)	1	Cha	121	lon	An	Of.	21228
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	brile	5				/ - /	- 1040		0
	Registr	ar	SEP 2 9 200	5 Block	30 K									

		•	For State Registrar	State	of Marylan		artmen rtificat					giene	005	31693
			1. Decedent's Name (First, Middl	e, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Alan Martin	Yinger							Septem			5 6:00 AM M
	Examin		4a. Fecility Name (If not institution	n, give street and n	umber)		4b. City,	Town, or	Location	of Death		4c. C	county of Death	n
			2831 Basehor						ytown		0.5		roll	
	Funeral		5. Social Security Number	6. Sex 15☑M 2□F	7. Age (In yrs.	Vre	Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day	y, Year)	Cou	nplace (State or Foreign untry)
ě	Director		215-56-1084 Usual Residence of Decedent	71	54						Nov 21.	, 195	U [Mary	yland
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Man	ţċ	MD Carr	ro11		Taney	town							1 □ Yes 2√ No
	th the	irec	10e. Street and Number				10f. Zip	Code					en of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. Inthe than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	2831 Basehore	es Mill R	oad				21787				USA	
	tems	une	11. Marital Status	Armed F	cedent Ever in U. orces?	S. 13.	Was D <i>e</i> ce If Yes, spe	dent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	- 14	 Race - Amer Black, White 	
9	s afte	by Fi	1 ☐ Never Married 2 🙀 Mar 3 ☐ Widowed 4 ☐ Divorced	nied 1 ∐ Yes If Yes, 0 Year or	2 No Sive X		1 □ Y <i>e</i> s	2∏ No	Specify:			S	Specify: wh	ite
2	tural sale			nt's Education	Dates.	16a. Dece	dent's Usu	al Occupa	ation		unk	16b. Kind	d of Business/I	
<u>.</u>	n ne	Completed	(Specify only highe	st grade completed		(Give	kind of wo DO NOT u	rk done o	turing mos	t of worki	ng			,
7	yiene r tha	Eo	Elementary/Secondary (0-12)	O.	(1-4or 5+)									
aug	e filed Il Hyg othe	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden S	lumame)	
	uld b Menta prked	70	Clarence Lawre	nce Yinge	r				Anni	e Ir	ene Edm	ondsc	on	
an L	2 should be filed within 72 hours after death wi and Mental Hygiens is a marked other than "netural", or tems 23a. I s marked other than "netural", or tems 23a. raumatic event, the Medical Examiner must b		19a. Informant's Name/Relations				-				l Route Numbe			(ip Code)
≥	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Memtal Hygiene. If Health and Memtal Hygiene a fathow filem 21 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at		Mary Pat Ying	er/spouse					es Mi		oad Tan	_		21787
9	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	~ ~	lace of Dispo emetery, crei	matory or o	ne or ther plac	e)		ate	20c. Loca	ation - City or 1	lown, State
Baltimor	tant:		* 4 Donation 5 Other (S		./	22 11								
n D	permit. Pages Department of t Important: If ite any injury or of once.		21. Signature Funeral Servi	S. Wade,	victor		2. Name ar State Baltir	Ana	comy	Board 2120	d 655 W	. Bal	timore	Street
	200		23a. Part1. Enter the disease, o shock, othean failure. List	r complications that t only one cause on	caused the death each line.	h. Do not ent	er the mod	le of dyin	g, such as	cardiac c	r respiratory ar	røst,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		ESPICE	TOC4	fa	ulu	re					Onset and Death
	/Medical		resulting in death)	Due to	o (or as a conseq		•							
	Examiner		Sequentially list conditions, if any, leading to immediate		ETELSTE		Lu	14	Ca	nce	V-			
-6	sit ad	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence ot):		_						
_	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to	o (or as a consequ	uence of):								
8/6U,		lical E			· · · · · · · · · · · · · · · · · · ·	,								
/80	certificate nding phys use as the	edic		d										
XOR	that the death certifics ed by the attending ph detached for use as t	Z/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		-					23	3d. Date of deli	very
ă	death e atten	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	birth 2 Feta gnant at time of d		∃Ectopic p ∃Other <i>(s</i> į						Month	Day Year
j.	t the by the	hys	9 Unknown	9∐ Unl	nown									
ν. T	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditi	_		0.1		ause giv	en in Part I	l.	23e. Did to	obacco use		the cause of death?
ecords,	en sig		Idiopart	ric Pul	MONAN	+10	1150m	.		_	1 🗆 1	∕es 2□	No 3∏Pro	obably 4
ပ္	> ~ ~	plet	SIP La	ing Tr	ansplan	10					24a. Was autop	an	24b. Were au	topsy findings available completion of cause of
r	The	Completed)	•						perfo	rmed?	death?	2 No
Vital	Physician: r this certifica ral director, p	Be (25. Was case referred to medical examiner?							e of Death	(Check only o	ne)		
0	hysic his co	2	1 Yes 2 No			ER/Outpatie			7					oily home
ב	Ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time o Injury		28c. Injun Wor			28d. Døscribe t	now injury	occurred	
<u>s</u>	r Attending P ler death. rector: After i by the funera	cati	2 Accident invest	not be			M		Yes 2 🗆		19f Location /	Ctro at a sad	Number of Bu	ral Route Number,
Division	or Al	Certification:		nined 288. Pla	ce of Injury - At he Iding, etc. (Specif		reet, ractor	у, опісе			City or Tox	vn, State)	Number of Au	rai Houle Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	C	29a. Certifier 1 Certifyi	ng Physician: To t	he best of my kno	wledge, deat	h occurren	at the tin	ne, date ar	nd place.	and due to the	cause(s) a	and manner as	stated.
	24 h	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina anner stated.	tion and/or in	vestigation	, in my o	pini on, d<i>e</i>a	ath occurr	ed at the time,	date and p	place, and due	to the cause(s)
	To th Mithin To th compl	Me	29b. Signalure and title of certific	er O			29	c. Licens	a number				signed (Month	•
			bust !	5.0-	-, ms		1.	000	375	70		91	22/05	-
			30. Name and address of persor	who completed ca	use of death (Item	n 23a) (Type.	Print)							
			Jonathan		ns, MI									
	Sta Regist	ate	31. Date filed (Month, Day, Year SFP 2	9 2005	Registrar's Signa	M A	346	7						
	negist	TEI	Whit W	- LUUJ /	18 128 9 A. C. A.	A Bridge	ALL PROPERTY.							

			1 = For State Registrar	State of Ma	ryland	I / Depa <i>Cer</i>	rtmen tificat	t of Ho	ealth and N Death		giene Reg. No.	005	31694
	Physicia	an	1. Decedent's Name (First, Middle, Last)	4.7.1			1 .1			2. Date of De Month		5, 2005	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st	Alphon:	se A.	AVIC			Location of Death	Septem	-	County of Death	
	Examin	ier	Byron House Assis		ng			omac				ontgome	
	Funeral		5. Social Security Number 6. Sex	44 OFF		st birthday)	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Col	nplace (State or Foreign untry)
	Director		126-01-8576 X	^{M 2□ F} 8	6	Yrs.				October	r 5, 1	.918 New	York
	and and		10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
	Mary B-1-sh	tor	Maryland Montgomer	у		Potoma	ac						1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number				10f. Zip					en of What Co	
	sath w	srai	9210 Kentsdale Dri	.Ve 2. Was Decedent B	uor in II S	12 14	Vac Doon		0854 spanic Origin? (Sp	pointy Ves or No		ed Stat	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: if then 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, the Moulcal Examiner maint be notified at Angle.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:		If	Yes, spec	ofy Cubar	Specify:	Rican, etc.)		Black, White	, etc.
3	sture con E		15. Decedent's Educ	ation		16a. Deced	ent's Usua	I Occupa	tion		16b. Kir	nd of Business/I	ndustry
3	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	OO NOT u	e retired)		ang			
7	led wi lygien her th it, the		17. Father's Name (First, Middle, Last)	2		Syste	ems A		St 18. Mother's Nam	o (First Middle		rtment	Store
<u> </u>	d be fi	o Be	Alphonse A. Avita	hile						sca Coc		Jumamey	
<u> </u>	shoul ind Me i mark umati	2	19a. Informant's Name/Relationship (Typ			19b. Mailin	g Address	(Street a	nd Number or Rui			Town, State, Z	ïp Code)
Ž	and 2 saith a n 27 is		Nancy Avitabile /	Daughter					Blvd., B				
ב ב	ges 1 t of He ff iter or oth		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Re	moval from State	Cel	nce of Dispos metery, crem	atory or o	ther place	Sept	Date ember		cation - City or 1	
	iit. Pa intmen injury injury		4 □ Donation 5 □ Other (Specify) 21. Signature/of Funeral Service Ligense	a /	WOOd	d1awn				2005		x, New	
ם מ	Department Department		Magdelle Dur	of		305 75	57 Wis	consi	n Avenue,	Bethesda,	Mary	sda-Chevy 1and 208	
			23a. Part1. Effer the disease, or complic shock, or heart failure. List only one	e cause on each lin	Θ.					or respiratory a	rrest,	de si cari periodi di salam di salam di salam di salam di salam di salam di salam di salam di salam di salam di	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Conges		Cardi	Lomyo	path	У				
	Examiner		b is a second se			rtery	Dise	ase					Years
-	D #	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a	ı conseque	ance of):							
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):							
000	ficete be executed physicien and is the burial-transit	dical E	d.										
0	rtificet ng phy as th	0	IF FEMALE:										
200	ath ce strendi	Physician/M	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1 ☐ Live birth	2 🗍 Fetal (death 3 🗌	Ectopic p				2	3d. Date of deli- Month	very Day Year
- -	the de y the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	atn 5	Other (sp	өспу)					
'n.	w requires that the death certific been signed by the ettending p should be detached for use as	by Ph	Part II. Other significant conditions conf	ributing to death bu	it not resul	ting in the un	derlying o	ause give	n in Part I.				the cause of death?
cords,	requir een si hould	sted									Yes 2∑	1 -	obably 4 □Unknown
	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Completed								24a. Was auto perfo 1 \(\text{Yes} \)	psy ormed?	prior to death?	topsy findings available completion of cause of
VILA	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:				Othe	26. Place of Dea			¥	Assisted
5	Phys arthis arat di	5. To	27. Manner of Death	28a. Date of Injur	y :	R/Outpatient 28b. Time of		Bc. Injury	at Nursing H	28d. Describe			h) Living
5	ath. rr: Afte	ation	1 X Natural 5 Pending 2 Accident investigation	(Month, Day	(Year)	Injury	м	Work 1 □ Y	res 2 □ No				
DIVISION	al or Atte safter de l Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At hor :. (Specify)	ne, farm, stre	et, factor	y, office		28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	edicai C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin one)	ician: To the best of er: On the basis of and manner sta	examinati	viedge, death on and/or inv	occurred	at the tim , in my op	e, date and place, pinion, death occur	and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier				29	. License	number			signed (Month	
	.06		> SM / Myses	· ·				D	25818		Sept	ember 2	6, 2005
1	4		30. Name and address of pers in the cor Sean M. Dwyer, M.I					e. C	hevy Cha	se. Mar	vlan <i>ć</i>	20815	
W	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra				-, 0			,		
	Registr		SEP 3 0 2005	Fife St.	15	1	4357						

Amend item#17, perFH G848 10/4/05 TT State of Maryland 7 Department of Health and Mental Hygiens 0.0 F 1 - For State Registra 31695 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:20 A.M SEPTEMBER Jargaret 29 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE SAMARITAN GOOD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X Pottsville, PA 178-01-434(Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-1 ehow the Medical Examiner must be notified at 1 Yes 3 No raekvil Baltimole WD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 5.A Avenue 21234 52 14 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 5 Specify: þ Widowed 4 □ Divorced white "netural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Mean once. College (1-4or 5+) Elementary/Secondary (0-12) 19 memaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Saxon Be Margaret 19a. Informant's me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore M.D. 21284 8214 Harris Avenue - (ckughter) Schimpf Jeanne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) oct. 1,200st Baltimole, Marylond Moreland 21. Signature of Funeral Service Licensele 22. Name and Address of Facility BALTIMORE, MD 21234, EVANS FUNERAL CHAPE L 8800 HARPORD RD.

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pant1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL Physician /Medical Due to (or as a consequence of) Examiner RENAL FAILURE ACU TE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit UROSEPSIS resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2UNI2 YNDROME 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?

↑□ Yes 2 □ No 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 🖵 🗲 Titying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER, 29, 2005 M.D 8 itoude 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD GAITONDE 5601 LOCH RAVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Klow It foods

ORIGINAL

BANZ

			State of Maryland / Department of Health and Mental Hygiene 1 - State State Certificate of Death Reg. No.	005	31696
	Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Last) Marion Banz 4a. Facility Name (If not institution, give street and number) 2. Date of Death Month Day 4b. City, Town, or Location of Death	Year 2005 County of Death	3. Time of Death
	Funeral Director		4241 Novisville Rd Unite Hall 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 3. 19	9. Birtho 21 MAR	Clace (State or Foreign try)
	e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location White Hall	1	0d. Inside City Limits
	be filed within 72 hours atter death with the Maryland ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Majical Esoninar must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citize 11. Marital Status 12. Was Decedent Ever in U.S. Agmed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	en of What Coun	an Indian,
21215-0036	2 hours after atural', or Ite	by	3 Widowed 4 □ Divorced Year or Dates:	Black, White, Specify: Who	rite.
	filed within Hygiene. other than "	e Completed		PS. Sumame)	
Maryland	2 should and Mer Is marke aumatic	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rulal Route Number, City or	Town, State, Zip	Code)
Baltimore, I	00		1 (Burial 2 Cremation 3 Removal from State Cometery, crematory or other place) 4 Donation 5 Other (Specify)		wn, State
Balt	permit. Pag Department Important: I any injury o		23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest,	MO 2 ARFORD	RP. Approximate Interval Between
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of): CONCESTIVE HERR T FAILURE	_	Onset and Death
1	be executed sician and burial-transit	Examiner	Sequentially list conditions,		
68760,	ate hy	caj	d		
.O. Box	res that the death certific signed by the attending p be detached for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Divide birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown	3d. Date of delive Month	Day Year
Records, P.	The law requires that the lab seen signed by the base been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	No 3 Prob	ably 4 []Unknown
Vital Rec		Be Completed	25. Was case referred to medical 26. Place of Death (Check only one)	prior to cor death? 1 🗆 Yes	psy findings available inpletion of cause of
of	ding Phys n. After this funeral di	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	. , ,	()
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	al Certification;			
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and p and manner stated. 29b. Signature and title of pentition 29d. Date	signed (Month, i	the cause(s) Day, Year)
16	H	2	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SERVIND H. KAVITEM. D. 560/LOCH RAVENBIVD. BATTIMUNE	MANYI	MO21239
	Sta Registi	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPT. 2¹9 200⁵5 **Physician** 1:10AM BOOKER CORNELIUS HERMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A FUTURECARE - HOMEWOOD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1√ M 2□ F Yrs. 285-44-6541 73 Director 11/09/1931 **GEORGIA** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examiner mast be notified at 1 XYes 2 No Director N/A BALTIMORE CITY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1838 E. 29TH STREET 21218 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. iges 1 and 2 should be filed within 72 hours after it of Health and Mental Hyglene.
If item 27 is marked other than "natural" or tea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) B. GREEN GROCERY CO DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LILLIE NORWOOD CORNELIUS BOOKER, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1838 E. 29TH ST., BALTIMORE, MD 21218 PATRICIA BOOKER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ➡Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) injury or permit. Page Department of Important: If any injury or once. KING MEM. PARK 10/3/05 RANDALLSTOWN, 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Juneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD H. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EROTIC CARDIOUASCULAR **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 4 Donknown PROLIFERATIVE 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 versing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 □ Accident 5 Pending 1 Tes 2 🗌 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 NORTH RACTIMORE CEASAN) STREET 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State SEP 3 0 2005 Registrar

		For State					of Health a	and Me	ental Hy	giene	005	31698
		1 - State Registamend item 1. Decedent's Name (First, Middle,	#5 Per Fl	H G848	10/06/	05° TH	UI Dealii	2	2. Date of Dea	ath		3. Time of Death
Physic /Medi		Virginia Lee l	Bachman						Month Septeml	Day ber 2		5 12:25 A ^M
Exami		4a. Facility Name (If not institution,	-				vn, or Location o	of Death		4c.	County of Dear	
		Charlestown Ret		ommunit 7. Age (In yrs.		Caton If Under 1	sville ear IfUnder:	24 Hrs. 5	R Date of Birt	h	Baltim 9 Bid	thplace (State or Foreign
Funeral Director		5251 ial Security Number 212-12-3563	1 M 2 M F	80	Yrs.		ays Hours	Min.	B. Date of Birt (Month, Da 11/4/1	y, <i>Year)</i> 924	Co	insylvania
		Usual Residence of Decedent		140.00	-							10d, Inside City Limits
anylar show	7	10a. State 10b. County MD Balt:	imore		ty, Town or Lo Ltonsvi							1 ☐ Yes 2 No
the M 28a-1	Director	10e. Street and Number				10f. Zip Co	de			10g. Citiz	zen of What Co	ountry?
h with	al Di	715 Maiden Choi	ce Lane			212	28			Uni	ted Sta	tes
ems 2	Funeral	11. Marital Status		ident Ever in U	.S. 13. \	Was Deceden	of Hispanic Orig Cuban, Mexican	gin? (Spec i, Puerto R	ify Yes or No ican, etc.)		14. Race - Ame Black, Whit	encan Indian,
S afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or Da	'e		1□Yes 2፟⊠	No Specify:				Specify:	White
2 hour	ted t	15. Decedent	s Education		16a. Deced	ient's Usual C	ccupation	4 - 6		16b. Kir	nd of Business	/Industry
9. " " " " " " " " " " " " " " " " " " "	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	1		lone during mosi etired)	t or working				
led wi lygien her th		9	- net		Commu	nicati		r's Name	(First, Middle,			City Gov't
d be fi	Be	17. Father's Name (First, Middle, L Clinton England	asi)						ulton	maidon	oum a no,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other treumetic event, Ite Modified at any Injury or other treumetic event, Ite Modified at any Injury or other treumetic event.	10	19a. Informant's Name/Relationsh	ip (Турв, Print)		19b. Mailir	ng Address (S	treet and Numbe			er, City or	Town, State,	Zip Code)
and 2 alth a alth a 27 Is		Sandra McCoy /	daughter				Ave. La					
or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from	State	Place of Dispo	natory or othe	r place)	Da			cation - City or	
t. Pag rtmen rtent:		*4 □Donation 5 □Other (Sp 21. Signature of Funeral Service L	11 11	вау	view C		1	9/30/				Maryland of Lansdowne
Departing any Ir		21. Signature of Pulleral Service C	ZINO	ll								ryland 2122
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that comby one cause on e	aused the deat ach ling.	th. Do not ent						,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a M	etast	ahe	mal	Lynaut	Met	940.	uq	- pra	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		/		r			
	ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consec	quence of):							
cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
icate be executed physician and sthe burial-transit	Ex	resulting in death) Last	Due to (or as a consec	quence of):							
	dicai		d									
The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregni		Ectopic pregi	22004			2	3d. Date of de	
death	Physician/M	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)		ant at time of o		Other (speci					Month	Day Year
hat the d by th		9 ☐ Unknown Part II. Other significant conditio			sulting in the u	nderlying caus	se given in Part I.		23e. Did to	obacco u	se contribute to	o the cause of death?
signe	d by	Takin emeralis				, , , ,	3		10	Yes 2	⊒No 3□P	robably 4 Unknown
w requires to been signed should be	Completed								24a. Was		24b. Were a	utopsy findings available
The la te has	шо									ormed?	death?	completion of cause of
	Be C	25. Was case referred to medical examiner?						of Death	(Check only c	one)		
Physicien: r this certific ral director,	L _O	1 Yes 2 No	Hospital: 1 🔲 I	·	ER/Outpatier				e 5 Resident		Other (Spe	ecify)
ding Afte fune	tion	1 Natural 5 Pending 2 Accident investig	(Mont	th, Day Year)	Injury	м	Injury at Work? 1 Yes 2				,	
Attending ar death. ector: After by the fune	ertification:	3 Suicide 6 Could r	ned 286. Place	of Injury - At h		reet, factory, o	ffice	2	8f. Location (S City or Tox			ural Route Number,
itel or rel Dir lled in	O											
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical		g Physician: To the Examiner: On the ba and mani									
To the within To the	Me	29b. Signature and title of certifier	JV d	W	1.111	29c. L	icense number	1 ->	- W	29d. Date	e signed (Mont	th, Day, Year)
		1 9		(,			000	20	040		9/29	9/05
57		30. Name and address of person	who completed caus	se of death (Item 7	m 23a) (Type,	Print)	(liet	ul	Car	W.	Cotte	unalle
S	tate	31. Date filed (Month, Day, Year)	32. R	Registrar's Sign	ature	w					1	18
Regis		SEP 3 0 2	005	and the	1294	Se de						2 (778

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. **16**. U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29, 2005 Year RICHARD H. BOWEN SEPT. 2:30 P.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) ARNOLD ANNE ARUNDEL FUTURECARE CHESAPEAKE 8. Date of Birth (Month, Day, Year) APRIL 1, If Under 24 Hrs. 6. Sex 1 🕅 M 2 ☐ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1907 MARYLAND Months Days Hours 98 Yrs. 217-32-1724 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 21401 270 BELLE RIVE DRIVE 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Important: If them 27 is marked other than "netural: or limportant is them 27 is marked other than "netural: or limportant is not the property or other than the property or other than the property in th

Physician

/Medical

Examiner

10a. State

Funeral

Director

Physician /Medical Examiner

Physician/Medical Examiner The law requires that the death certificete be executed signed by the attending physician end d be detached for use as the buriel-transit Be Completed by Medical Certification: To

Division of Vital Records, P.O. Box 68760,

ᅙ	MARYLAND ANNE AF	RUNDEL	ANNA	POLIS				163 22210
<u>2</u>	10e. Street and Number			10f. Zip Code		10g. (Citizen of Wha	t Country?
<u></u>	270 BELLE RIVE I	RIVE		21401		UN	ITED S	TATES
ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto F	city Yes or No-		American Indian, White, etc.
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced			1 ☐ Yes 2 No		,	Specify:	WHITE
eted	15. Decedent's l (Specify only highest g		16	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of workin	16b.	Kind of Busin	ess/Industry
omp	Elementary/Secondary (0-12) 5	College (1-4or 5	5+) FA	ARMER			AGRICUI	RLTURE
9	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle, Maide	en Sumame)	
2	HERMAN BOWEN				EDITH UN			
•	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address (Street	and Number or Rura	l Route Number, City	y or Town, Sta	te, Zip Code)
	F. DALE MILLS /	DAUGHTER		570 CHURCH RD	., ARNOLD			
	20a. Method of Disposition 1 Aurial 2 ☐ Cremation 3 4 ☐ Opnation 5 ☐ Other (Spec		cemet	of Disposition (Name of ery, crematory or other place MONT MEM. GAR	DENS O	CT. 3		y or Town, State
	21. Signal Funeral Service Lice	^		22. Name and Addres	ss of Facility DDICK FUN	ERAL HOME	, P.A.	
	230 Port Foto no disease or co	mplications that caused	the death Dr	421 CRAIN			UKNIE,	Approximate
	23a. Part1. Enter the disease, or conshock, or heart failure. List on	y one cause on each li	ne.	y not order the mode of dyn.	_			Interval Between Onset and Death
	Immediate Cause (Final	0		Live Heo	ct For	71		
	disease or condition resulting in death)				11 cu	uure		
4		(Due to (or as	a consequence of):				
Ē		b						
Xan	Sequentially list conditions, if any, leading to immediate		Due to (or as a	a consequence of):				
e E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
ğ	resulting in death) Last		Due to (or as a	a consequence of):				
3		d						
ciar						90h Didtebee		hute to the seven of death?
ysi	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlying cause giv	en in Part I.			bute to the cause of death? □ Probably 4 □ Unknown
돈	Huperte	75100				1 Tes	2 NO 3	_Probably 4_Olikilowii
Completed by Physician/Medical Examiner	18	/ \				24a. Was an au	topsy 2	4b. Were autopsy findings
etec	Dement	701				performed?		available prior to completion of cause
du	7	VERE NE				2022/00/20	1	of death?
င်	Dyspha	910				1 Tyes	212 No	1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?	V		Oth	26. Place of Death			
0	1 ☐ Yes 2 12 No		1 .			ne 5 Residence		Specify)
ation:	27. Many of Death 1 V atural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Date on	iry Year) 28b	. Time of 28c. Injury Wor 1 □	yat k? Yes 2 □ No	28d. Describe how in	jury occurred	
ertific	3 Suicide 6 Could not determine	A Z86. Place of III]	jury - At home, c. (Specify)	farm, street, factory, office	2	28f. Location (Street City or Town, Sta		or Rural Route Number,
Medicai Certification:	29a. Certifier (Check only one)	Physician: To the best aminer: On the basis of and manner st	f examination a	ge, death occurred at the tin and/or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the cause ad at the time, date a	(s) and manne and place, and	er as stated. due to the cause(s)
Ø Z	29b. Signature and title of certifier			29c. Licens	e number	29d. [Date signed (A	fonth, Day, Year)
	MI	11		MD L)507	25 9.	-29	- 2005
,	BO Name and address of person who	completed cause of c	death (Item 23a	601 leter	ans Hi	hway	Mills	ersville Mi
е	31. Date filed (Month, Day, Year)	32. Brigistr	ar's Signature	-				21108

noite 31. Date filed (Month

DHMH 16 Rev 6/95

State Registrar

		1. Deced	te pistrar dent's Nam	e (First, M.	iddle, La	st)			00	illica	te of L	Jealii		2. Date of D Month	Reg. No.		Year _	3. Time of	Death
hysicia /Medic							Irice	B. E	3race y	/				Sent	24	2	200	4:03	51
xamin		_	_			e street and		v= 01	640	-	, Town, or			,			of Death		
			Security N		295h	المراجع		(loves l	(†R ast birthday)		en B	If Under		8. Date of B	d'ne	7-6	9. Birtho	nde,	r Forei
ineral rector		2	225-68-		1	1 □ м 2√2		59	Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Year) 5, 1945		Coun	aryland	
f show	ō	10a. Sta		10b. Cou	inty	Arundel		10c. City	, Town or Lo	ocation	Gle	n Burni	e				10	0d. Inside Cit	
a or 28a.	Funeral Director	10e. Str	eet and Nu	mber ey Road						10f. Z	ip Code	2106	31		10g. Citize	en of W	/hat Coun	-	
ns 23	erai		tal Status	y i toau		12. Was [Decedent E	ver in U.	S. 13.	Was Dec	edent of Hi	- 171		cify Yes or N Rican, etc.)	0- 14		- Americ	an Indian,	
Important: If Itam 27 is marked other than "natural, or Itams 23s or 28s-f show any injury or other traumatic event, the Middical Examinar must be notified at once.		1 🗆	Never Marr	ried 2 l		1 DY	d Forces? es 2 ☑ N . Give or Dates:	o		_	ecnfy Cuba 2 □x No			Hican, etc.)		Black Specify:	k, White, 6	etc. Hack	
n "natur	Completed by	Flore		15. Dece cify only hi	ghest gra	ade complet	ed) ge (1-4or 5-		16a. Dece (Give life.	dent's Us kind of w DO NOT	ual Occupa rork done d use retired	ation during mos	t of workir	ng			siness/Inc	lustry ostal Ser	vico
ar tha	E O	Eleme	12	ondary (0-1	2)	Colleé	Je (1-401 5-	-)			Postal	Mail Cl						USIAI SEI	vice
7 Is marked other then " traumatic evant, the Mus	To Be	17. Fath	er's Name	(First, Mid		d Brace	y					18. Mothe	er's Name	(First, Middle	uby Bra		э)		
la ma rauma						Турө, Print)								i Route Numi ore, Mary			State, Zip	Code)	
am 27 thar t			thod of Dis	cey Mo	tner			20b. P	lace of Dispo	osition (N	ame of			ate			City or To	wn, State	
Important: If Itam 27 Is any injury or othar tra once.		1 🛭	Burial 2			Removal fr	om State	Ce	emetery, cre. Glen H	matory or	other place		(07/30/05			n Burni		
injur				uneral Sen		-	7				and Addres							,	
any ir		•	ÜÜ	ayo	1	25	Cer	1		E	step B	rothers	ace Ba	al Service Itimore, N	larvland	_21:	217	_	
sician edical		Immedi	ate Cause or condition g in death)	(Final	List only	a	_	h'c	Shi	ter the mo	ode of dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Betv Onset and E	ween
edical miner	ai Examiner	Sequen if any, le cause Cause that init	ate Cause or condition	(Final on on ditions, mmediate erlying ripiny)	List only	b. Due	Sep	tic consequ	uence of):	ter the mo	ode of dying	g, such as	cardiac o	r respiratory	arrest,	-		Interval Bety	ween
attending physician and in policy for use as the burial-transit and large at the burial-transit and large at the policy of the p	icai	Immedidisease resultin Sequentif any, I cause. Cause that init resultin IF FEM 23b. W. in 15	ate Cause or conditing in death) trially list consequence eading to in Enter Undi (Disease or inted event g in death)	(Final on on on on on on on on on on on on on	$\left\{ \right.$	a	Sep to (or as a to (or as a	tonsequence of pregna 2 Fetal	uence of): uence of): uence of):	ck	pregnancy	g, such as	cardiac o	respiratory	arrest,	3d. Date Mon	e of delive	Interval Betwonset and E	ween
by the attending physician and ached for use as the burial-transit	by Physician/Medicai	Immedidisease resultin Sequenif any, leause. Cause that init resultin IF FEM 23b. W in 1 [9 [ate Cause or condition of the condition	(Final on on on on on on on on on on on on on	{	a	o to (or as a to (or a))))))))))))))))))))))))))))))))))))	tronsequence of pregnate 2 Fetal lime of definitions of the control of the contro	uence of): uence of): uence of):	□Ectopic □ Other (s	pregnancy	g, such as	cardiac o	23e. Did	arrest,	Mon e contri	ith	Interval Betwonset and E	ween Death
has been signed by the attending physician and the burial-transit of p. 2 should be detached for use as the burial-transit of p. 2.	by Physician/Medicai	Immedidisease resultin Sequenif any, leause. Cause that init resultin IF FEM 23b. W in 1 [9 [ate Cause or condition of the condition	(Final on on on on on on on on on on on on on	{	a	o to (or as a to (or a))))))))))))))))))))))))))))))))))))	tronsequence of pregnate 2 Fetal lime of definitions of the control of the contro	uence of): uence of): uence of): uence of):	□Ectopic □ Other (s	pregnancy	g, such as	cardiac o	23e. Did	23 tobacco usi	Mon e contri No 24b. W	ibute to th 3 Proba	ry Day Y	ween Death 'ear eath?'
ate has been signed by the attending physician and Union bage 2 should be detached for use as the burial-transit	e Completed by Physician/Medical	Immedidisease resultin Sequenif any, I cause, Cause that init resultin IF FEM 23b. W in 1 [9 [9 Tart II. ()]	ate Cause or condition of the condition	(Final on on on on on on on on on on on on on	ditions	a	o to (or as a to (or a))))))))))))))))))))))))))))))))))))	tronsequence of pregnate 2 Fetal lime of definitions of the control of the contro	uence of): uence of): uence of): uence of):	□Ectopic □ Other (s	pregnancy specify) cause give	en in Part I	cardiac o	23e. Did 1 □ 24a. Wa aut	tobacco use Yes 2	Mon e contri No 24b. W	ibute to th 3 Proba	ry Day Y ce cause of deably 4 U copy findings a nipletion of cause.	ween Death 'ear eath?'
Iter this certificate has been signed by the attending physician and Iterator, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedidisease resultin Sequenif any, I cause. Cause that init resultin IF FEM 23b. W in 10 10 10 10 10 10 10 10 10 10 10 10 10	ate Cause or condition of the condition	onditions, mmediate errlying rinjury s. Last	ditions	a. Due b. Due c. Due d. 23c. If yes yellow yell	o to (or as a to (or a))))))))))))))))))))))))))))))))))))	consequence of pregnature of deliberations of deliberations of the consequence of the con	uence of): uence of): uence of): uence of):	Ectopic Other (s	pregnancy specify)cause give	en in Part I 26. Place 30. 4 □ Nu / at / 27.	e of Death	23e. Did 1 □ 24a. Wa auto	tobacco use Yes 2 S an ppsy ormed? No one) idence 6	Mon e contri No 24b. W p dd	ibute to th 3 Probi	ry Day Y e cause of deably 4 U ossy findings a npletion of ca	ween Death 'ear eath?'
Iter this certificate has been signed by the attending physician and Iterator, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedidisease resultin Sequenif any, I cause, Cause that init resultin IF FEM 23b. Win 1 [9 [Part II. ()] 25. Waa exa 1 [27. Mar 23]	ate Cause or condition of the condition	onditions, mmediate errlying rinjury so Last Int pregnant 2 months? No nificant con No tth 5 Period Control of Cont	ditions	a. Due b. Due c. Due d. 23c. If yes 1 L L 4 P 9 U contributing Hospital: 28a. D	o to (or as a to (consequence of pregna 2 Fetal time of delation of the consequence of t	uence of): uence	Ectopic Other (s	pregnancy specify) cause give	g, such as en in Part I 26. Place ar: 4 \(\) Nu	e of Death ursing Hor	23e. Did 1	tobacco usa Yes san Service on the control on the c	Mon e contri No 24b. W pl dt 1	ibute to th 3 Probi Vere autoprior to coneath? Yes	ry Day Y e cause of deably 4 U ossy findings a npletion of ca	ween Death /ear eath? Jnknov availal ause (
Iter this certificate has been signed by the attending physician and Iterator, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Immedidisease resultin Sequenif any, I cause, Cause that init resultin IF FEM 23b. W in 1[9] Part II. (25. War exa 1 27. Mar 27. Mar 29a. Ce	ate Cause or condition of the condition	onditions, mmediate errlying rinjury ss. Last Int pregnant 2 months? No no ifficant con No ifficant con I No de Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge	ditions dition	a. Due b. Due c. Due d. 23c. If yes 1 Li 4 P 9 U contributing Hospital: 28a. D in 28a. P hysicien: Tominer: On til	o to (or as a to (consequence of pregna 2 Fetal time of delime of my kno examina	uence of): uence	□Ectopic □ Other (some of the content of the course of th	pregnancy specify)	g, such as 26. Place 27. 4 \(\) N 4 t 7. Yes 2 \(\)	e of Death ursing Hor	23e. Did 1	tobacco use Yes 2 S an pormed? No one) idence 6 how injury (Street and wn, State)	Mon e contri No 24b. W pl dd 1 Othe occurre	ibute to th 3 Probi Vere autoprior to coneath? Yes or (Specify) ar or Rura.	ry Day Y e cause of de ably 4 Du osy findings a npletion of ca 2 No	/ear /eath/
Iter this certificate has been signed by the attending physician and Iterator, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedidisease resultin Sequenif any, I cause. Cause that init resultin IF FEM 23b. W In 10 9 (0 Part II. (1) 25. War 27. Mar 27. Mar 29a. Ce (0 0	ate Cause or condition of the condition	onditions, mmediate errlying rinjury ss. Last Int pregnant 2 months? No no ifficant con No ifficant con I No de Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge Ge	ditions didical anding restigation and the termined diffusion of the t	a. Due b. Due c. Due d. 23c. If yes 1 Li 4 P 9 U contributing Hospital: 28a. D in 28a. P hysicien: Tominer: On til	o to (or as a to (consequence of pregna 2 Fetal time of delime of my kno examina	uence of): uence	□ Ectopic □ Other (some of the courrent of th	pregnancy specify)	26. Place 26. Place 37. 4 Nu 4 At Yes 2 The pinion, dea	e of Death ursing Hor	23e. Did 1 1 24a. Waauto per 1 Yes 1 Check only me 5 Res 28d. Describe 28f. Location City or To	tobacco use Yes 2 S an pormed? No one) idence 6 how injury (Street and wn, State)	Mon e contri No 24b. W pl pl pl pl pl pl pl pl pl pl pl pl pl p	were autoprior to coneath? If Specify and or or Rura.	ry Day Y e cause of deably 4 U ossy findings a npletion of ca 2 No I Route Numb the cause(s)	/ear /eath? Johnnon
this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and in a contraction, page 2 should be detached for use as the burial-transit or property.	edical Certification; To Be Completed by Physician/Medical	Immedidisease resultin Sequenif any, I cause. Cause that init resultin IF FEM 23b. W In 10 9 (0 Part II. (1) 25. War 27. Mar 27. Mar 29a. Ce (0 0	ate Cause or condition of the condition	conditions, mmediate entrying rinjury stast ast ast ast ast ast ast ast ast a	ditions didical anding restigation and the termined diffusion of the t	a. Due b. Due c. Due d. 23c. If yes 1 Li 4 P 9 U contributing Hospital: 28a. D in 28a. P hysicien: Tominer: On til	o to (or as a to (consequence of pregna 2 Fetal time of delime of my kno examina	uence of): uence	□ Ectopic □ Other (some of the courrent of th	pregnancy specify)	26. Place 26. Place 37. 4 Nu 4 At Yes 2 The pinion, dea	eardiac o	23e. Did 1 1 24a. Waauto per 1 Yes 1 Check only me 5 Res 28d. Describe 28f. Location City or To	tobacco use Yes San Spsy ormed? No one) idence 6 how injury (Street and wn, State) cause(s) a date and p	Mon Mon Mon Mon Mon Mon Mon Mon Mon Mon	ibute to the solution of the s	ry Day Y e cause of deably 4 U ossy findings a npletion of ca 2 No I Route Numb the cause(s)	eath? death fear availal ause of

Bracey Lrice

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H	lealth and <i>Death</i>		piene 005	31702
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Yea	3. Time of Death
	/Medic			Ann Bell	L	1		SEP	29, 2005	
7	Examin	er	4a. Facility Name (If not institution, give s 2811 Greenlawn R			4b. City, Town, o	r Location of Dea ${ m d}1{ m awn}$	ith	4c. County of De	
			5. Social Security Number 6. Sex		e (In yrs. last birthday)	If Under 1 Year		s. 8. Date of Birth		Limore Birthplace (State or Foreign Country)
	Funeral Director			M 2X1F	56 Yrs.	Months Days	Hours Mir			country) arvland
	ъ		Usual Residence of Decedent		T			1100 -0	3 - 2 1 2 1 2 2	
	arylan show	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Be-1:	ecto	Maryland Baltimo	re		Woodlawn			10g. Citizen of What	
	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 show deal Examiner must be notified at	Funeral Director	10e. Street and Number 2811 Greenlawn Roa	nd		10f. Zip Code	21207	1	USA	Country?
	ns 23	eral		2 Was Decedent	Ever in U.S. 13.	Was Decedent of H		Specify Yes or No- rto Rican, etc.)		merican Indian,
(0	ifter d v Iten	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑	No			rto Rican, etc.)		
03	rali, o	i by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
215-0036	72 h "netu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	orking	16b. Kind of Busine	ss/Industry
121	within iene. then "	du	Elementary/Secondary (0-12)	Callege (1-4or 5	ō+)	ce Manage			Construct	tion
d 21	filed Hygid Sther		17. Father's Name (First, Middle, Last)		0222	oc minage		ame (First, Middle,		1011
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "neturel; or items 23e or 28e-1 show or other treumatic event, it is Marical Examiner must be notified at	To Be	John Donell Frase					bara Mar		
Nar	12 sh h and 7 Is m reum		19a. Informant's Name/Relationship (Ty)			•			r, City or Town, State	Col. II.
	of Health of Health litem 27 I		Albert P. Bell, Jr	./nuspane	20b. Place of Dispondentery, cre	L Greenla osition (Name of		Wood Law	n, MD 2120 20c Location - City	
Baltimore,	ages ant of it: If it y or o		1 ☐ Burial 2 GCremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	i		_ 9/3	30/05	Baltimore	
İ	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Final Service License	9. 0 1	Metro_Cre	PMA FOLV. 2. Name and Addre	IDC .	-	land, Inc.	
B	permit. Departr Importe eny inji		Dawn F. McT	ionald	0	799 Frede	Society rick Ros	oi Mary. d Raltin	nore. MD 2	21228
	36		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused e cause on ea sali	the death. Do not en	ter the mode of dyin	ng, such as cardia	ac or respiratory arr	rest,	Approximate Interval Between
	Physician	П	Immediate Cause (Final disease or condition	C	weal	Como	~			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
	- Zaminoi	-	Sequentially list conditions, if any, leading to immediate	. Due to (or as	a consequence of):					-
	uted I Insit	Examiner	Cause (Disease or injury		,					
Ć.	exection and and rial-tra	Exa	resulting in death) Last		a consequence of):					
8760,	ires that the death certificate be executed signed by the attending physician and deelached for use as the burial-transit	dical								
9	e as t	Med	IF FEMALE:		,					2-14-5
Вох	death ce e attend ed for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy	1		23d. Date of o Month	delivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant al 9□ Unknown	time or death 5t	Other (specify)				
م	that the by detail	y Ph	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	requires een sign nould be	d by						1 🗗	es 2 No 3	Probably 4 Unknown
CO	> 0 10	Completed						24a. Was a	an 24b. Were	autopsy findings available o completion of cause of
Re	0 <u>c</u> 0	E O						autops perfor 1 Yes	m⊷eot? ∣ death	es 2□No
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or	ne)	
of <	Physicien: this certific ral director,	2	1 ☐ Yes 2 No	ospital: 1 Inpatie			4 🗆 i turaing	-	ence 6 □Other (S	pecify)
n o		on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o Injury	Wor		28d. Describe h	ow injury occurred	
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Ini	ury - At home, farm, st		Yes 2 □ No	28f Location /S	treet and Number or	Rural Route Number,
Division	after of Direction by	Certification:	4 Homicide determined	building, et	c. (Specify)	reet, factory, office		City or Town	n, State)	rara route rumber,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge, deal f examination and/or in	h occurred at the tir	ne, date and place	e, and due to the coursed at the time.	cause(s) and manner	as stated.
	the H hin 24 the F mplete	Medical	one)	and manner st	ated.	29c. Licens			29d. Date signed (Mo	
	To To		29b. Signature and little of certifier			250. Elberts	28.0 -		9/3	0/05
			3) me and address person who ca	mpleted cause of	leath (Hem 23a) Type	Print)	704	1	1	1
	1		Tour and addition will be	50A . //		This	24/1	20	La Cel	-Q-1
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	1	, - /		-	
	Regist	rar	SEP 3 0 20	05	and the fa	DOCES!				

CT05-06542 Amend Unpend Type of Print in 1932k Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Barnhill, Curt 1 - For State Registrar 005 Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Kurt William Schulz Barnhill 25, 2005 1:25 PM September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital
5. Social Security Number 6. Sex Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. N/A 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Aug 14, 2004 9. Birthplace (State or Foreign Funeral Days 212-71-3098 1 Yrs. Director Aug Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Timonium Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 11 Dickens Square 21093 **USA** Funeral Pages 1 and 2 should be filed within 72 hours after death itama; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Sherrie Schulz Barnhill David Hamilton Barnhill ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Sherrie S. Barnhill, Mother 11 Dickens Square Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 09/28/05 Baltimore, Maryland 21. Signature of Funeral Service Lice Thomas Gregor 22 Name and Address of Facility
Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Hyperthermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician ar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐Unknown been si 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? death? 1 Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 X Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ After thi The ate of Injury

Time of Injury

Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death Exposed with might environmental 1 Natural 2 Accident 5 Pending investigation 11:30AM death. 9/23/2005 1 Yes 2 No tempurature ector: / by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number. City or Town, State) **IIOII McCornick Roa** 4 | Homicide Cockeysville, MD 29a. Certifie

within 24 hours after de To the Funeral Directo To the Hospital

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

September 26, 2005

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUB10 MD

111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER **Physician** 28, 2005 5:00P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Eacility Name (If not institution, give street and number Saint Joseph Medical Examiner Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 9. Birthpface (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 717-07-9450 Yrs. U.Caroli Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "neturel", or Items 23s or 28s-f show 1 ☐ Yes 2 No SALTIMORE Director ALTMOR 10g. Citizen of What Country? 10e. Street and Number 1 لح Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Ie marked other than " Elementary/Secondary (0-12) Colfege (1-4or 5+) or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First. Middle, Last) amie ပ . Informant's Name/Relation nship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD TIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State thod of Disposition Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. DALTIMORE 4 □ Donation 5 □ Other (Specify) BALTIMORE, MOZIZZY. 21. Signature of Funeral Septice License 22. Name and Address q Facility EVANS FUVERAL CHAPEL 800 HARFORD RC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** DAY /Medical Due to (or as a consequence of): Examiner RENAL FAILURE MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or 2) Hospital 1 Yes 2 ER/Outpatient Certification: To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) postient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Marner of Death 28b. Time of 28d. Describe how injury occurred Infury Naturat 5 Pending Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier D25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ILIA CEBALLOS 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 3 0 2005 Registra DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Maryla		artment of F		Mental Hy	rgiene Reg. N2	15 31705
			Decedent's Name (First, Middle	e, Last)					2. Date of D		3. Time of Death
	Physici /Medic		Evelyn M	. Cor	tezi				Septem	ber 29,	2005 4:30 a M
	Examin		4a. Facility Name (If not institution Dak Crest Car	. •	umber)		4b. City, Town, o		th	4c. County Balt	of Death :imore
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hr	8. Date of Bi	^{rth} 2 ^{ay} 1 ^y B ^{ar)} 1913	Birthplace (State or Foreign Country)
	Director		214-40-5875	1 □ M 2 □ X F		91 Yrs.			November	.18,1913	Maryland
land	M m		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
Many	He 1-8	tor	MD Ba	ltimore		Parkv	ille				1 ☐ Yes 2 ☐ No
ith the	or 28	Director	10e. Street and Number	D1 (74	06		10f. Zip Code 21 23	1.	-	10g. Citizen of V	· ·
leath w	ns 23a must 1	Funerai	8810 Walther	12. Was De	cedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or N	o- 14. Rac	e - American Indian,
III X I X I 3-0000 Be filed within 72 hours after death with the Maryland	al', or Iten	ρ	1 ☐ Never Married 2 ☐ Mar 3 🕱 Widowed 4 ☐ Divorced	If Yes. G	2 □XNo Sive		If Yes, specify Cuba 1 ☐ Yes	Specify:	rto Rican, etc.)	Specify	ck, White, etc. ^{y:} White
2 Po 62	natura Sical E	eted	15. Deceder	nt's Education st grade completed	()	(Give	dent's Usual Occup	durina most of w	orking	16b. Kind of Bu	usiness/Industry
vithin .	ne. han "	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired stered Nu	3)		Nurs	ina
illed C	Hygie other t	e Co	17. Father's Name (First, Middle,	Last)		1,092	00101		ame (First, Middle	e, Maiden Suman	
9 p	lental rked o tic eve	To B	Ralph			Cynth	nia		Jones		
nd 2 shou	27 is mair r treumair		19a. Informant's Name/Relation:		er			ress (Street and Number or Rural Route Number, City or To West Timonium Rd., Timonium			
artificatory, mit. Pages 1 a	Department of Health and Mental Hygiene. Importent: or Items 23a or 28a-f show Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		- Ctata	cemetery, crei	osition (Name of matory or other place Cemetery		Date /1/05		City or Town, State
permit.	Departrimporte any Inju		21. Signature of Funeral Service	Licensee Will	iam G.						
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the de	ath. Do not en	ter the mode of dyir	ng, such as cardia	ac or respiratory	arrest,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	a	3/200	4	ance				Onset and Death Month
	Medical kaminer		resulting in death)	Due to	o (or as a conse	equence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due te	o (or as a conse	equence of):					
cate be executed	physician end the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С							
oroo,	ician e buriat	ai Ex	resulting in death, cast	Due to	o (or as a conse	equence or):					
ficate	physics the	edicai		d							
To the Hospitel or Attending Physicien: The law requires that the death certifi	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 1s months? 1 □ Yes 2 Wo 9 □ Unknown	1 🗀 Live	utcome of preg birth 2 Te gnant at time of nown	tal death 3	⊒Ectopic pregnancy □ Other (specify) _	/			te of delivery onth Day Year
that t	ned by detai	by Ph	Part II. Other significant condit	ons contributing to	death but not re	esulting in the u	ınderlying cause gıv	en in Part I.	23e. Did	tobacco use cont	tribute to the cause of death?
acolus, law requires t	been sign								1 🗆	Yes 2□No	3 Probably Unknown
The law re	ite has beo	Completed				· · · ·			24a. Was auto perf 1 \(\text{Yes}	opsy ormegr? c	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♠No
VILCI Icjen:]	ertifica ictor, p	Be C	25. Was case referred to medical examiner?					-	eath (Check only	1	
Physic V	this ca al dire	은	1 ☐ Yes 2.5 No			ER/Outpatie		442 Nursing		how injury occurr	
ding	h. After funer	tion	27. Manner of Death Natural 5 Pendi	ng (Mo	e of Injury onth, Day Year)		Wor	k? Yes 2 □No	200. Describe	now injury occurr	80
UNISION Or Attending	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	27. Manner of Death All Autural 2 Accident 3 Suicide 4 Homicide 4 Homicide All Autural 288. Date of Injury - At home, farm, street, factory, office 288. Place of Inj								(Street and Numb own, State)	per or Rural Route Number,
e Hospite	24 hours e Funeral letely filled	edical C	29a. Certifier (Check only one) Certifyi Certifyi Certifyi	ng Physician: To t I Examiner: On the and ma	he best of my ki basis of exami anner stated.	nowledge, deat nation and/or in	th occurred at the till evestigation, in my c	ne, date and place pinion, death occ	ce, and due to the curred at the time	cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of central	er			29c. Licens				d (Month, Day, Year)
							01	5111		Jephan	-1234
	6		30. Name and address of person	an 88	00	1410 h	Print) Black) Pari	tulle	w 2	-1234
	Sta Registi	late 31. Date filed (Month, Day, Year) 32. Registrar's Signature									

		1 - State Registrar			Cen	tificate	of L	Death		Reg. No	ر ک	U D	31/00
		Decedent's Name (First, Middle, La	ist)						2. Date of I	Death Da	av	Year	3. Time of Death
Physic /Med		Margaret W. C	orun						Septen	ber		2005	10:59 A™
Exami		4a. Facility Name (If not institution, given	re street and number)			4b. City, To	wn, or	Location of De	ath	40	c. County	of Death	
		2219 Chapel Val				Timon:					altin	more	
Funera		, , , , , , , , , , , , , , , , , , , ,	1 M 2 E	(In yrs. last bi		If Under 1	Year Days	If Under 24 H Hours M	in. (Month,	Dav. Year)	Count	
Director		213-34-0998 Usual Residence of Decedent	X	70	Yrs.				July 3	, 19	35	Mary	land
and		10a. State 10b. County		10c. City, Tov	m or Loc	ation						10	0d. Inside City Limits
Mary f ehc	ō	MD Baltimo	re	Timoni	um								1 ☐ Yes 2 🛣 No
288 100	Director	10e. Street and Number				10f. Zip C	ode			10g. C	itizen of W	Vhat Count	try?
3a of		2219 Chapel Val	lev Lane			2109	93			USA			
death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Deceder	nt of Hi	spanic Origin?	(Specify Yes or I	No-		e - America k, White, e	
or its		1 ☐ Never Married 2 💢 Married	1 Yes 2 XNO	0	i	☐ Yes 20		Specify:	eno moan, etc.)		Specify:		AC.
if 5, IMALY INTELLATIONS STAND	d by	3 Widowed 4 Divorced	Year or Dates:									Ш	hite
72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	(Give k	ent's Usual (доле с	lurina most of v	vorking	16b. H	Kind of Bu	siness/Ind	ustry
within 00.	lg m	Elementary/Secondary (0-12)	College (1-4or 5+			O NOT use		•		To	lophe	C	
ther t		12 17. Father's Name (First, Middle, Last	<u> </u>	Pe	rson	nel Ma	эпа		lame (First, Midd				ompany
od o	Be	Joseph M. Wya						Margar		11 _y		-/	
should manke umarke	70	19a. Informant's Name/Relationship		198	o. Mailine	Address (5	Street		Rural Route Nun		or Town.	State. Zio	Code)
Mar d 2 sho lih and lih and traum		William M. Coru							ane; Tin				
Heelth Heelth tem 27		20a. Method of Disposition	11 / Huaba	20b. Place o	f Dispos		of	1.00	Date	-	ocation -		
Peges nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	•	•		1	/20 /05	T4-	noniu	- M	`
를 필든원들.		21. Signature of Funeral Service Lice		штатч				rdens 9/	20703				Road
Depa impo		1 Cal V	10/1		R	uck To	oldsi	on Fune	ral Home				D 21204
		23a. Part1. Enter the dispase, or conshock, or heart failure. List only	plications hat caused t	the death. Do									Approximate Interval Between
Physician		Immediate Cause (Final									4 0 444		2 Vr5
/Medical		disease or condition resulting in death)	Due to (or as a	consequence	of):	syva	m	0000	ell car	617	, 0000		
Examiner		Conventinity lies and disions	5Kin	can	cer								"
1 n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a										
ransi	Examiner	Cause (Disease or injury that initiated events	c										
sicien a		resulting in death) Last	Due to (or as a	consequence	of):								
ate b hysic the b	Medical	•	_ d										
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours elter death. To the Funeral Director: After this cartificate has been signed by the attending physicien and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	Mec	IF FEMALE:	22a If upo outcomo o	d aragnanay									
ath c	-	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1☐Live birth 2	Petal death		Ectopic preg					23d. Date Mon	e of deliver oth I	ry Day Year
the d	Physician	1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	ime oi death	3□	Other (spec	''iy)						
that the sed by detac	Ph	Part II. Other significant conditions	contributing to death but	t not resulting	in the und	derlying cau	se give	en in Part I.	23e. Die	d tobacco	use contri	ibute to the	e cause of death?
sign d be	d by					, ,	•		10	Yes 2	2 □ No	3 🗌 Proba	ably 4 Unknown
requipe property	Completed								24a. Wt		24h W	Vara auton	ay findings available
e lav	μ								- au	opsy	240. W	rior to com leath?	esy findings available appletion of cause of
Th. Th											o 1	☐ Yes	2) No
sicien carti	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	• a□ EB/O		20 DOA	Othe		eath (Check only Home 5 Re				
rthis and d	2	27. Manger of Death	1 Inpatien	/ 28b.	Time of		. Injury Work	4 Nursing	28d. Describ				,
After Part of the	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м		(? Yes 2∐No					
Atter dea	Certification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injur	ry - At home, fa	arm, stre	et, factory, o	office					er or Rural	Route Number,
d in the state of	ert	4 Homicide determined	building, etc.	(Specity)					City or I	own, Stat	Θ)		
spitu hours mera y tille		29a. Certifier 1 Certifying Pl	hysician: To the best of	my knowledg	e, death	occurred at	the tim	e, date and pla	ice, and due to th	e cause(s	s) and mar	nner as sta	ated.
n 24 l	Medical	(Check only 2 Medical Exa	miner: On the basis of e and manner state	examination ar ed.	nd/or inve	estigation, in	my op	oinion, death oc	curred at the tim	e, date an	d place, a	ind due to	the cause(s)
To the To the To the Comp	ž	29b. Signature and title of certified	1.			1		number			ate signed		•
) / you	1/2				D	0047	625		91	28/6	05
100		30. Name and address of person who	Mi		(Type, F	Print)		0 .					11.
		Richard	O'maile		D	760	0	Ser	Dr SU	ite.	311	10Ws	o5 son Md 212
	ate	31. Date filed (Month, Day, Year)	32. Registra	's Signature									
Regis		SEP 3 0	2005	he die	A. Car	astle 1				_		_	
DHMH 17 Rev 1/	2001		Justin	"البيالي حب	Maria	A A A							
				C	RIGI	VAL							

			1 - State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of H			giene 005	31707
	Physici		1. Decedent's Name (First, Middle, Last) Salvatore E	rnest Ca	aramagno			2. Date of De Month Sept	Day 29, 2005	3. Time of Death 5:15A M
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of D		4c. County of Dea	th
			3102 Teal Lane 5. Social Security Number 6. Sex	7 A	ge (In yrs. last birthday)	Bowi If Under 1 Year		Hrs 9 Date of Bid	Prince G	
	Funeral Director			M 2□F	73 Yrs.	Months Days		Min. (Month, Da	y, rear) Co	thplace (State or Foreign ountry) Sachusetts
	put &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla faho	ξ	Maryland Prince (George's						1 ☐ Yes 2 ☒ No
	th the or 28e	Directo	10e. Street and Number	20160 8	<u> </u>	10f. Zip Code			10g. Citizen of What Co	buntry?
	ath wil		3102 Teal Lane				715		USA	
30	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-f ahow int. The Modical Examiner count be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Deceden Anned Forces Yes 2 [If Yes, Give 	1949	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Ame Black, Whit Specify: Wh	e, etc.
Š	2 hour		15. Decedent's Educ		16a. Deced	dent's Usual Occup	ation		16b. Kind of Business/	
9500-61212	d within 72 giene. ir than "ni	Completed	(Specify only highest grade	Completed) College (1-4or	life. I	kind of work done DO NOT use retired TNEY	during most of d)	f working	Self Emplo	·
ana	_ 0 0	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	•	
<u>Z</u>		ပ	Domenico Caramagno 19a. Informant's Name/Relationship (Type		dob Advilla		Anna			
Z	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Carol J. Caramagno	•				e, Marylai	er, City or Town, State, 2 and 20715	(ip Code)
ore,	of Hea of Hea fitem rothe		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Re	-	20b. Place of Dispo			Date	20c. Location - City or	Town, State
Баппрог	Pages tment of tant: If it jury or o		`4 ☐ Donation 5 ☐ Other (Specify)		Metro Cr			9/30/05	Baltimore,	Maryland
pa	permit. Pages 1: Department of He Important: If iten any injury or oth		21. Signature of Funeral Service Linense Thomas Grezor	y	2	Name and Addre remation 99 Freder	ss of Facility Societ ICK RO	y Of Maryl ad Baltimo	land Inc. ore, Maryla	nd 21228
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that cause cause on each	ed the death. Do not enti- line.	er the mode of dyin	ig, such as car	rdiac or respiratory ar	rest,	Approximate Intervat Between Onset and Death
	Physician / /Medical	7.7	Immediate Cause (Final disease or condition resulting in death)	Due to (or a	s a consequence of):		-11/0			37000.
	Examiner		Sequentially list conditions, b.							
Н	ed British	Examiner	cause. Enter Underlying Cause (Disease or injury	Dua to (or s	s a consequence of):					
,	execut n and ial-trar	Exan	that initiated events c. resulting in death) Last	Due to (or a	s a consequence of):					
0/8	ite be iysicia ne buri	dical	d.							
٥	eath certificate be executed attending physician and for use as the burial-transit	0	IF FEMALE:							
C. Box	the death certificate be executed by the attending physician and ached for use as the burial-transi	hysiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)	<i>'</i>		23d. Date of deli Month	very Day Year
7		by Ph	Part II. Other significant conditions conf	ributing to death	but not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
	w requires that been signed b should be deta						-	_ 1 U Y	'es 2XNo 3∏Pri	obably 4 Unknown
II Records	The law ate has b page 2 sl	Completed						24a. Was a autop perfor 1 Yes	sy prior to d mgd? death?	topsy findings available completion of cause of
VII		o Be	25. Was case referred to medical examiner?	ospital:		Oth		Death (Check only or	-/	
õ	g Phys er this eral di	H-	1 ☐ Yes 2 No ☐ 10 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		28c. Injur	y at		ence 6 Other (Spec	ify)
	Attending r death. ector: After by the fune	atlo	1 ★Natural 5 Pending 2 Accident investigation	(MOHIII, DA	ay Year) Injury	M 1	Yes 2 □ No			
DIVISION	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, e	njury - At home, farm, stre tc. (Specify)			City or Tow		
	Hosp 24 hou Fune Fune	ledical	29a. Certifier (Check only one) (Check only one) (Check only one)	cian: To the besi er: On the basis and manner s	t of my knowledge, death of examination and/or inv	occurred at the ting restigation, in my o	ne, date and pi pinion, death o	lace, and due to the o occurred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To thi within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (Month	, Day, Year)
	11		1 Challe				3440	3	7/29/0	5
(810		30. Name and address of person who cor	•			Cui to	2034 Parria	MD 20716	
	Sta	te	Andrew S. Dobin, M.		North Hanso	on court	ourte.	ZOOA DOWIE	, PID 20/16	
	Registr		SEP 3 U 200	5 200	co 0 60					

			1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment of F rtificate of	lealth and N Death	Mental Hygi	005	31708
15		75	1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici /Medi		Robert Paul Cor	nor				Septembe	Day Year	10:55 PM
	Examir		4a. Facility Name (If not institution, giv	. 1			Location of Death		4c. County of Death	
	*	<i>*</i>	Saint Agnes	Hospital			more			
	Funeral Director		5. Social Security Number 6. S	5ex 7. Age (In □35M 2□ F 53	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 13)	9. Birth Cou 1952 Mar	place (State or Foreign intry) YLand
	pg &		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	acation				
	fanyli ed e	5			-					10d. Inside City Limits 1 ☐ Yes ※XXNo
	28a-	Director	Maryland Baltin 10e. Street and Number	ore		3altimore		10	g. Citizen of What Cou	
	3 with	٥	4932 Gateway Ter	race			1227	, 0,	USA	into y :
	death	Funeral	11. Marital Status	12. Was Decedent Ever		Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian,
215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or itame 23s or 28s-f show event, the Medical Exprit at medical tall for the medical	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2版No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White, Specify: Whi	
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Business/In	ndustry
2	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	0	ang		
21	Hygier Hygier ther th	S		5⊹	Assis	stant Pri			Education	1
pur		Be	17. Father's Name (First, Middle, Last) William Henry Co					e (First, Middle, Ma		
Ĕ	should be nd Mental marked c	င္	19a. Informant's Name/Relationship (-	401. 14. 11			hy Hayder		
Maryland	C1 (C) (E) (A)	ř.			1 85				City or Town, State, Zip	
	Health Health tam 27 other tra		Maura Connor 20a. Method of Disposition	Wif	Ob. Place of Dispo	sition (Name of			e, Maryland	
OL.	ages ant of t: # i y or e		1 ☐ Burial 2 M Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		matory or other plac ort Crema			exandria,	,
Baltimore,	permit. Pages Department of It Important: If its any injury or of		21. Signature : Fur eral Service Liter			Name and Address Sterling	S Ashton S	Schwab Fu	neral Home	Inc.
	40240		JULCI C	. (1)		/36 Edmor	<u>idson Ave</u>	nue;Cator	isville, M	21228
			23a. Part1. Enter the diseast or com shock, or heart failure. List only Immediate Cause (Final					or respiratory arres	t,	Approximate interval Between Onset and Death
5	Physician /Medical		disease or condition resulting in death)	a		VARI	CES			10 days
	Examiner			Due to (or as a co		ARICES				10 To 20
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co		TICICES				augs
À	uted d ansit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
0,	licate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a con	nsequence of):					
68760,	ate b	edicai		. d.						
_		Med.	IF FEMALE:	00-16						
O. Box	ires that the death certifii signed by the attending t I be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
P.O.	that the ted by the detache	Y Ph	Part II. Other significant conditions c	ontributing to death but no	t resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
ds.	law requires as been sign 2 should be	d by	CIRRHOSIS	OF LIV					2 ⊉No 3 □ Prob	
ဂ	w requires to been s	ete	HEPATITIS	C. V 18	LUS IN	FECTION)	24a. Was an	24h Wore auto	psy findings available
Re	0 - 0	Completed	1.01.11.11.13		- US IN	PENON		autopsy performe	d? prior to co	mpletion of cause of
ita	ë ∯ 5	Bec	25. Was case referred to medical examiner?		140-		26. Place of Deatl	h (Check only one)	TI Tes	Z BE NO
<u></u>	Physicia this cert al direct	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	4 Nursing Ho	me 5 Residence	e 6 □Other (Specif	y)
Division of Vital Records,	ding After	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
isi	Attending in death.	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		At home farm etc.		′es 2 □No	29f Location /Ctra	et and Number or Rura	10-11
Ω	s after al Dire	Certification:	4 Homicide determined	building, etc. (Sp	pecify)	eet, ractory, ornee		City or Town, S	State)	i ribule Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Ph	ysician: To the best of my liner. On the basis or examiner, and manner stated.	knowledge, death mination and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	se(s) and manner as si and place, and due to	tated. the cause(s)
	To th within Fo th	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Month,	Day, Year)
)) 630	arali		A524	38528 -	Se	ptember,	26,2005
	19	1	30. Name and address of person who of VAQUA BA	0 15		Print)	A10a)	1.15 1	r ()	MD 21229
	Sta	te	31. Date filed (Month, Day, Year)			100 (.	-, 10/~ /	100 05	altimore	1011001009
	Registr	ar	SEP 3 0 2005	2. Registrar's S	of Appen	E.				

CONNOR, ROBERT

		-	For State	State of Mai	•	epartment of H			0000	21700
			Ragistrar 1. Decedent's Name (First, Middle, L	act)		Certificate of I	Death	2. Date of Deat	ag. k UU5	3. Time of Death
	Physicia		Anne The In		lin			- Month	Day - Ye	
	/Medic Examin		4a. Facility Name (If not institution, g		0 1	4b. City, Town, or	Location of Death		4c. County of E	Death 0.1
	LXamiii		Baltimore Was	y upthicity	78th cal	Center	(5) en	Brus.	mr	me hrmdy
	Funeral			Sex 7. Age 1 M 2 X F	(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCt. 21	Year) 9.	Birthplace (State or Foreign Country)
	Director		213-16-9393 Usual Residence of Decedent		86 Y	3.		UCT. 21	1918	MD
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mar	ctor	Maryland Anne	Arundel		P	asadena			1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number			10f. Zip Code	04400	1	0g. Citizen of Wha	
	sath v		104 Margaret Av	12. Was Decedent Ev	ver in IIS	13 Was Decedent of H	21122	pecify Yes or No-	US 14 Bace : A	A American Indian,
10	r item	Funerai	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No		13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, V	White, etc.
036	rai', o	Ď	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
21215-0036	4 within 72 hours after death with the Maryland liene. I then "netural", or Items 23a or 28a-f show Ite Medical Examiner must be netified at	Completed	15. Decedent's (Specify only highest of			Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of world	king	16b. Kind of Busin	ess/Industry
12	within ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	Clerk	1)		Motor Veh	nicle Admin.
0 0	Hygi Hygi ther	Be Cc	17. Father's Name (First, Middle, La	st)		- OTOTA	18. Mother's Nam	ne (First, Middle, I		TTOTO Admitts
lan		To B	Charles R.	Stamm			Julia	Che1kov	vski	
Maryland	C 8 8 8	65 3	19a. Informant's Name/Relationship			Mailing Address (Street				
	s 1 and 2 f Heelth item 27 other tr		Diane Zeller	(daughter		47 Terra A1 Disposition (Name of			a Alta,	
Baltimore,	5 0		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3		cemetery	, crematory or other plac	Sept.	. 2/		
Itin		1	* 4 □ Donation 5 □ Other (Spe 21. Signature of Films at Service Lice	7/1-	Me tro	Crematory I 22. Name and Addre				, Maryland Home, P.A.
Ba	permit. Departr Importe any inje	6 4	I blild.	1		3111 Mou			dena, MD	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused to	he death. Do no	ot enter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician	(i) li	Immediate Cause (Final disease or condition	_a_	000	restrue	- He	- T	Failw	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	7 = 1	V31/22	· ~		
		- E	Sequentially list conditions, if any, leading to immediate	b. Due to (or a a	consequence o):	v ilimii			
\$	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<i>H</i>	men	rtung	~			
0,	The law requires that the death certificate be executed title has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a	gnsequence o):				
8760,	hysici	dicai		d						=
ļφ	ding p	/Med	IF FEMALE:	23c. If yes, outcome o	f pregnancy				23d. Date of	deliven
O. Box	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year
þ.	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown						
S, D	igned I	by P	Part II. Other significant condition	s contributing to death but	not resulting in	the underlying cause giv	en in Part I.			te to the cause of death?
ord	w require been sign	ted						190	es 2 No 3	Probably 4 Unknown
Records,	e law r has be	Completed						24a. Was a autops perforr	y prior	e autopsy findings available r to completion of cause of
alF								1 ☐ Yes	2000 10	
Vital		o Be	25. Was case referred to medical examiner?	Hospital: Inpatien	t 2 ER/Out	patient 3 DOA Oth	20	th (Check only on	ence 6⊟Other <i>(.</i>	Specify)
of			27. Manner of Death	28a. Date of Injury (Month, Day	28b. T		v at		ow injury occurred	Specify,
sior	ttending F death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investiga	ion			Yes 2 □No			
Division	i or Att after de Directe	Certification:	3 Suicide 6 Could no 4 Homicide determin		y - At home, far (Specify)	m, street, factory, office		28f. Location (St City or Town		or Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier TS Certifying	Physician: To the best of	mv knowledae.	death occurred at the tir	me, date and place	and due to the c	ause(s) and manne	er as stated.
	To the Hospite within 24 hours To the Funerel completely filled	Medical		ammer: On the basis of and manner stat	examination and					
	within To th	M	29b. Signature and title of certifier	2	1 000	29c. Licens	e number	2	9d. Date signed (M	ipnth, Day, Year)
,	1		Y		11)[1148	50~0	0	9/23	12005
	V		30. Name and address of person w	TEN,	301	ype, Print)	Dr.	6/20	Burns'	e, my
	Sta Regist		SEP 3 0	32 Registral	rs Signature	GORNE !	,			

		•	For State Registrar	State of Marylar	nd / Department <i>Certificate</i>	of Health and Ne of Death	Reg	2°005	31710
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las VERNICE 4a. Facility Name (If not institution, give GENESIS-HAMILT	M. CO		Town, or Location of Death		Day Year 9,2005 4c. County of Death	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 212 56 2714 Usual Residence of Decedent	7. Age (In yrs			8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign intry) MD •
	e Maryland ta-f show	ctor	10a. State 10b. County N/A	10c. C	ity, Town or Location BALTIMOR	Ε			10d. Inside City Limits X □ Yes 2 □ No
	eath with these 23a or 28	erai Director	10e. Street and Number 6040 HARFORD 11. Marital Status	ROAD 12. Was Decedent Ever in t	10f. Zip	Code 21214 ent of Hispanic Origin? (Sp		U.S.A.	
900	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23a or 28a-f show Te Medical Extraligit and be notified at	d by Funeral	1 X Xever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X 1 o If Yes, Give Year or Dates:	If Yes, spec	fy Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
21215-0036	within 72 ha	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 3 R D		16a. Decedent's Usua (Give kind of won life. DO NOT us	k done during most of won e retired)	king 16	Sb. Kind of Business/li NONE	ndustry
Maryland 2	should be filed ind Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) JAMES COLTO	ON		18. Mother's Nam	ne (First, Middle, Ma LLA HOLI	aiden Sumame) LOWAY	
	1 and 2 sho Health and Iem 27 is m		19a. Informant's Name/Relationship (7 ELLEN M. WILSO 20a. Method of Disposition	ON (daughter	2)140 N. L.	e of	. BALTO,		224
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ir a Medical Exactinatic and to notified at once.		1 Berial 2 Cremation 3 C 4 Conation Content (Specification 2). Security of Funeral Service Licen	GRI	CEN MOUNT (22 Name and CALVII	CEDM		SAL HOME	MD.
	Priysician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	/// 1412 F	E. PRESTON	ST. BA	LTIMORE.	MD. 21213 Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed with the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	licai Examiner	Sequentially list conditions, if any leading to transcollar cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	Quence of):	SKIN L	ILCER	S	
P.O. Box 6	he death certifics the attending ph ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic pre			23d. Date of deliver Month	very Day Year
	n requires that the dest been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying ca	ause given in Part I.	1	cco use contribute to	the cause of death?
il Records,		Completed					24a. Was an autopsy performe 1 Yes 2	prior to c	opsy findings available ompletion of cause of
Division of Vital	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatient 3☐ DO 28b. Time of Injury M	Other	ome 5 Residential	ce 6 □Other (Spec	ify)
Divisi	in the se	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory	, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Aedicai	(Check only 2 Medical Examone)	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nation and/or investigation,	in my opinion, death occu	rred at the time, date		to the cause(s)
)	To with	Σ	29b. Signature and tille of certifier	M'D	D	0062233			
	2		30. Name and address of person who DA MAW N. 00,			, POB#	303, B	ALTIMORE	MD 21239
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2	32. Registrar's Sign	14 Loub	,			

			_	State of Maryland / D		•		_egible.	
		•	State	•	Certificate of Death		Reg. Na.	005	31711
			Registrar 1. Decedent's Name (First, Middle, Last)		Joranioato di Boati		of Death	000	3. Time of Death
н	Physicia		CORENE		DAVIS	Monti	Day	2005	1.6.
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)	4b. City, Town, or Location		4c.	County of Death	
	LXamiii	CI	MANDR CARE	- ROLAND PARK N.	H BALT	THARE	=	N	IA
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. last birth		O A I I am	of Birth	9. Birth	place (State or Foreign
	Director		216-20-0570 101	M 2/AF 8/3 Y	rs. Months Days Hours	SEPT	8,192	70 5	TH CAROLINA
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		7		10d. Inside City Limits
	sho	5	1400:11 6.1b	/h.	Barren	(7, -1	/	1 X Yes 2 □ No
	the M	Director	10e. Street and Number	1/4	10f. Zip Code	ORE	10g diti	zen of What Cou	
	a or	ä	41 19 FAI	15 0000	7 / 5	119	log. plan	115/	<u>L</u>
	death with the Maryland ims 23a or 28a-f show	Completed by Funeral	11. Marital Status 12	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Or	igin? (Specify Yes	or No-	14. Race - Ameri	can Indian,
(0	r Iter	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 Kan	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical		2.)	Black, White,	etc.
03	el', o	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			Specify: BL	ACK
2-0	within 72 hours after ene. then "neturel", or Ite tre Moule all Examire	eted	15. Decedent's Educa (Specify only highest grade	ation 16a.	. Decedent's Usual Occupation (Give kind of work done during mos	st of working	16b. Kir	nd of Business/In	ndustry
7	ithin	d	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)				/
2	filed w Hygier other th	S	9+HGRADE	GE	NERAL SERVICE			ERSITY OF	MD HOSP, PELLEGE
and	be fi	Be	17. Father's Name (First, Middle, Last)	. 73.11	E <	er's Name (First, M	iddie, Maideri .	11	10
3	should ind Men ind marke umatic	P	19a. Informant's Name/Relationship (Type	a Print) 19h	Mailing Address (Street and Number	or or Pum I Pouto A	lumbar City or		CAID
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, it e Mailfall Examiner mail be mailfalled.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	LOSE FRIEND) 3	21261	5 FALLS +	2		
	1 an Heal tem 2		20a. Method of Disposition	20b. Place of	Disposition (Name of	Date		ration - City or To	
JO L	Pages nent of int; If it iry or o	- 0	1 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	o, crematory or other place) ON CEMETERY	10-01-0	5/01	15 DANIAL	E MARKAND
Baltimore,	글론본글 .	1	21. Signature o Furreral Service Licenses		22. Name and Address of Facili			FUNE	RAL HOME
ä	Depermine Depermine Permine Pe		HASIAW.	75	2013 EPH. F.	ILTON A		ALTO . 1	15.21217
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do n	ot enter the mode of dying, such as			1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		TIC CARDIOVAS			4SE	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of			, (30)		
Н	Examiner		Sequentially list conditions, b.						
7	sit sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or its a consequence o	1):				
Ø	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence o	f):				
760,	ate be executed hysician and he burial-transit	cai E		, , , , , , , , , , , , , , , , , , , ,					
687	ficate physis the	*****	0.						
Box	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	• C.		2	3d. Date of deliv	ery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		_	Month	Day Year
P.O.	that the death certifical ed by the attending phy detached for use as th	hys	9 □Unknown	9□ Unknown					
	The law requires that the death certifical tens been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions cont		the underlying cause given in Part I	I. 23e.			the cause of death?
ord	equir sen si ould	ted		nos 15			1 Yes 2]No 3 ☐ Prot	bably 4 Unknown
Records	ne law i has bo ge 2 sh	uple	COREBRO UT	Schenz P	TCCIDEN 1	24a.	Was an autopsy	prior to co	opsy findings available ompletion of cause of
=		Con				101	performed? Yes 2 No	death?	2 □ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Other	e of Death (Check			
of	d is	٦.	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	patient 3 DOA	ursing Home 5 28d Desc	Residence 6		(y)
	ding l h. After funer	tion	1- Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) In	jury Work? M 1 ☐ Yes 2 ☐		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	l or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, far	m, street, factory, office				al Route Number,
Ö	s after	Certification:	4 Homicide determined	building, etc. (Specify)		City	or Town, State)		
	e Hospitel or 24 hours afte e Funerel Dir etely filled in		29a. Certifier (Check only 2 Medical Examina	cian: To the best of my knowledge, er: On the basis of examination and	death occurred at the time, date an	nd place, and due to	o the cause(s)	and manner as s	stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ledical	one)	and manner stated.	-	an occanion at the			
١	Vith To	Σ	29b. Signature and title of certifier	M P	29c. License number			signed (Month,	
•	1,		Milland	111.0.	000 584	15 T	701	TEMBER	27 2005
	Y\		30. Name and address of person who con		Type, Print) AW STREET	BATI	MINE	MA	21201
	Sta	te	31. Date filed (Month, Day, Year)	2 NOCC H EU7 38. Registrar's Signature	-1	1711011	VICC		11 201
	Registi	100	SEP 3 0 2005	Marie St A	parle				

			1- For State of Maryland / Department of Health and Months of Registrar Certificate of Death		ene 2005	31712
•	Physici /Medic Examir	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Death Month 09/26,	Day Year /2005 4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 9. For index 2 Hrs. Months Days Hours Min. 1. Sex 1	8. Date of Birth (Month, Day,	Baltim 9. Birth Vocation Victoria	hplace (State or Foreign unity)
#	the Marylan r 28a-f show notified at	irector	10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10d. Zip Code	10	lg. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
ALF	n 72 hours after death with the Maryland "natural", or itema 23a or 28a-f show adical Evaninat must be notified at	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 4 Never Married 4 Never Married 5 Never Married 6 Never Married 7 Never Marrie	cify Yes or No- Rican, etc.)	14. Race · Amer Black, White	
215-003	"nal	pieted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 ☐ Yes 2 ☑ No Specify: 1 ☐ Yes 2 ☑ No Specify: 1 ☐ Yes 2 ☑ No Specify: 1 ☐ Yes 2 ☑ No Specify:	99	Specify: 6b. Kind of Business/li	hite.
FNE		To Be Com	17. Father's Name (First, Middle, Last) Tackson Faulkner Gisela	(First, Middle, Middle, Middle)		noton
40LK	1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Hiral 19c. Method of Disposition 20b. Place of Disposition (Name of	1 Dcus	City or Town, State, Zi	21286.
FH Baltimore,	permit. Pages Department of important: if it any injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ac-	7-05 F.	mo ziz	1 MIN
	Physician		23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. Hist only one gause on each line. Immediate Cause (Final	respirátory arres		Approximate Interval Between Onset and Death
, x	/Medical Examiner	er	disease or condition resulting in death) a. Massive upper gastrointestinal here pure to (or as a consequence of): Portal Hypertension Due to (or as a consequence of): Portal Hypertension Due to (or as a consequence of): Alcoholic cirrhosis	ro arverae		2-3 days Years
8760,	cate be executed obysicien and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Alcoholic cirrhosis Due to (or as a consequence of): d.			Years
P.O. Box 6	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)		23d. Date of deliv Month	very Day Year
ords, P	law requires that as been signed to 2 should be detailed.	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to t	the cause of death?
Division of Vital Records,	2 5 5	e Completed	25. Was case referred to medical 26. Place of Death		prior to co death?	opsy findings available ompletion of cause of
<u>></u>	Physician: this certific	To B	examiner?		ce 6 ☐Other (Special	ify)
ision o	fter ine	Certification:	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Bd. Describe how	injury occurred	ral Paula Number
Div	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		building, etc. (Specify) 29a. Certifying Physician: To the best of my knowledge death occurred at the time date and place are	City or Town,	State)	stated
	To the H within 24 To the Fi	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	d at the time, date	and place, and due to an and place, and due to a signed (Month,	to the cause(s)
	de		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	9	1/28/05	5
_			Nathan A. Dunsmore, M.D GBMC 6701 N Charles Street,	Baltimo	ora MD 2120	04
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2005			

Amend item#11, perriff, 6348, 10/6/05 11

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 28 Day Year **Physician** 2:10 PM Jerry Fields sentenber 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ballmare
If Under 1 Year | If Under 24 Hrs. Singi Baltimore Hospital 0 N/A 8. Date of Birth (Month, Day (Sept. 25 1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 62 Yrs NC 218-44-0752 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23s or 28s-f show other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 🛛 No Glen Burnie Directo Maryland Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? athert known as Juny Field 21061 7824 Woodside Terrace Apt. T3 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married White 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Apartment Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental h is marked of Fields Elizabeth Clifford Garfield Maxine Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Lucia B. Fields (spouse) 7824 Woodside Terrace Apt. T3, Glen Burnie,MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
eny injury or ott Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2005 Baltimore, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dis-se, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician CPSIS disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 2∏ No 1 Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death te of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina 1 Yes 2 No death. investigation the within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zimedical Examination on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certain 29c. License number 29d. Date signed (Month, Day, Year) RES-000 xakmbir 28,2005 MI) 3 ddress of person who completed cause of death (Item 23a) (Type, Print) Sinai Nelson, MI Hospitel Baltmore Raltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 3 0 2005

Goods

		1 - For State Registrar		State o	f Marylar	id / Depa	artmei	nt of H		and Me	ental Hy	gien Reg. N	2005	31711
Physic /Med		1. Decedent's Name (First, M April Dawn (reen	en							Sept. 23,		2005 Year	3. Time of Death 10:55p M
Funeral Director		4a. Facility Name (If not institute Montgomery Gets) 5. Social Security Number 213-64-6146	nera.	1 Hosp		last birthday) Yrs.	(Olney	If Under:	24 Hrs.	B. Date of Bir (Month, Da April]	th	Montgor	nery hplace (State or Foreign
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene 18 is marked other than "natural", or frema 23a or 28a-1 ehow or eumatic event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. Cou				ty, Town or Lo			1	E	zbrit i	19,	1953	Maryland 10d. Inside City Limits 1 □ Yes 2 □ No
	al Direc	10e. Street and Number 14300 Parkma	nor]	Cerrace	2			p Code 20853					itizen of What Co	ountry?
urs after deat al', or itema 2	by Funer	11. Marital Status 1 Never Married 2 3 Widowed 4 Divor	Married	If Yes, 2 No If Yes, Give X Year or Dates: Education grade completed) College (1.4 or 5.)			Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify: edent's Usual Occupation te kind of work done during most of working DO NOT use retired) Sales			orfy Yes or No lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		e, etc.	
filed within 72 hours at Hygiene other than "natural", or ent, the Medical Exami	Completed by Funeral Director		hest grade										Industry	
d 2 should be filed the and Mental Hyg 27 is marked other treumatic event,	To Be C	17. Father's Name (First, Midd Richard Reu 19a. Informant's Name/Relati	ben	Green		19b Mailir	na Addres	s (Street	Ma	rion	(First, Middle,	.ne	Brooks	
ss 1 end of Health Item 27		Martin L. Ter 20a. Method of Disposition 1 □ Burial 2 ★ Cremati	willi	ger/hu	State 20b. F	14300 Place of Dispo	Par	kman of other place	or Te	rrace Da	, Rock	vil	le, MD Location - City or	20853 Town, State
permit. Pages 1 en Department of Heal Important: If Item 2 eny Injury or other once.		4 □Donation 5 □Othe 21. Signature of Funeral Sen	(Specify)		/h0135	Ra	Name a	nd Addre	ss of Facilit	d Cre	mation		eltsvill rvices 9	e, MD 33 Gist Av
Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	, or compli- ist only or	0	aused the deat ach line. Varian (or as a consec	th. Do not ent	er the mo	de of dyin	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death 4 years
te be executed ysician and te burial-transit	Ilcal Examiner	Sequentially list conditions, if any, Jacums to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Oua to	or as a conseq									
The law requires that the deeth certifical ate has been signed by the attending phypage 2 should be deteched for use es the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2	1☐Live b	come of pregnation 2 Teta pant at time of cown	ıl death 3 □	Ectopic Other (s	oregnancy	,				23d. Date of del Month	ivery Day Year
w requires that the de been signed by the a should be deteched f	₽	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									id tobacco use contribute to the cause of death? □ Yes 2ਊNo 3□ Probably 4 □Unknow			
	Completed	25. Was case referred to me								_	1 Yes	psy ormed? 2EN	prior to death?	itopsy findings available completion of cause of 2 No
ysicla s certi directo	o Be	examiner? 1% Yes 2 No	-	lospital:	Inpatient 2 🔯	ER/Outpatien	ıt 3□ D	OA Oth			Check only o		6 □Other /Soe	c/h/)
Attending Physician: r death. ector: After this certific		27. Manner of Death 1 Natural 5 Pe 2 Accident inv	stigation	28a. Date		28b. Time of Injury	e of 28c. Injury at 28d. D			Residence 6 Other (Specify) cribe how injury occurred				
To the Hospitei or Attent within 24 hours effer death To the Funerei Director: completely filled in by the	Certification:	4 Homicide de	uld not be ermined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number City or Town, State) 28c. Location (Street and Number City or Town, State)						te)				
the Hospitel thin 24 hours the Funerel mpletely filled	Medical	29a. Certifier 1 Cert (Check only 2 Medione) 29b. Signature and title of 6	cai exami	ner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	vestigatio	n, in my o	ne, date an pinion, dea e number	d place, ar th occurred	nd due to the	date ar	nd place, and due	to the cause(s)
		30. Name and address of per	~9	empleted carre	se of death (Iter	NAZ n 23a) (Type	2		30414				ate signed (Monta otember 2	
∫∂ S Regis	tate	Dr. Jo. 31. Date filed (Month, Day, Y	nn H	erring	egistrar's Signa	1810	,	nce	Phill	ip Dı	ive, ()1ne	ey, MD	

		•	For State Registrar	State of Maryla		artment of H			giene	31715
H	Physici		1. Decement's Name (First, Middle, Last)	Conson	2. Date of Dea	_	3. Time of Death			
	/Medic Examin	_	4a. Facility Name (If not institution, gives 2207 Ash	0/2///	t	4b. City, Town, or	Location of Dea	th	4c. County of	
	Funeral Director		5. Social Security Number 6. Sex 219/05792	M 2 7. Age (In yrs	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h g y, Year)	Birthplace (State or Foreign Country) So. Carolina
Maryland 21215-0036	ryland thow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	the Ma	Director	Maryland N// 10e. Street and Number	4		Bit 10f. Zip Code	altimore		10g. Citizen of Wh	1 🖪 Yes 2 🗆 No
	h with		2207 Ashton Street			101. Zip 00d0	21223		_	U.S.A.
	d within 72 hours after deeth with the Maryland Jiene. r then "natural", or itams 23a or 28a-f show the Medical Evarther met be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.
	2 hour atural		15. Decedent's Educ	ation					16b. Kind of Business/Industry	
1218	within 7 ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done of DO NOT use retired	ouring most of wo nemaker	orking	0	Own Home	
d 2	Hyger in the	0	17. Father's Name (First, Middle, Last)			11011		me (First, Middle,	Maiden Sumame)	
ylar	Q 50 0	ToB	Doc Ro					elena Miller		
Mar	12 ha 7 ic		19a. Informant's Name/Relationship (Type Cassandra Garrison	e, Print)		ng Address <i>(Street:</i> 6 24 Shadysid			-	ate, Zip Code)
ore,	of H of H fiter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Received the second s		Place of Dispo	osition (Name of matory or other place	1	Date	20c. Location - Ci	ty or Town, State
Baltimore,	Pa ant:		'4 □ Donation 5 □ Other (Specify) 21. Signature of 9 neral Server icense			Memorial G		10/01/05	Baltim	ore, Maryland
Bal	permit. Departr Imports any Inju		21. Signature of Fineral Service Licens	1, 25/8	21)	2. Name and Addres Estep B		eral Service,	P.A. aryland 212:	
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e cause on each line.	cordicate of):	ic I.	0 1	n m		Interval Between Onset and Death
.O. Box 68760,	at the death certificate be executed by the attending physicien and tached for use as the burtal-transit	Physician/Medical Examine	that initiated events resulting in death) Last	Due to (or as a consection of pregners) 3c. If yes, outcome of pregners, outcome of pregners, at time of good Unknown	nancy tal death 3[□Ectopic pregnancy □ Other (specify) _			23d. Date Month	
S, P	res that igned to be deta	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.			ute to the cause of death?
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed							an 24b. We	☐ Probably 4 ☐ Unknown If autopsy findings available or to completion of cause of ath? If Yes 2 ☐ No
Vital		BeC	25. Was case referred to medical examiner?					1 ☐ Yes eath (Check only a	/	1103 2 110
of	Phys r this ral di	tion: To	1 Yes No 27. Mann Death I atural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?			\sim	✓ Firsidence 6 Other (Specify) ✓ escribe how injury occurred		
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined					28f. Location (S City or Tox	or Rural Route Number,	
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier Check only one)	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tire evestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and mann date and place, an	er as stated. d due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of contiller	~D		29c. Licens			29d. Date signed (
	1					1)36	786		9-29	-05
	X		30. Name and address of person who co	2 m.D. /15	em 23a) (Type,	- RE, 4	len Bu	-nie/ M	D 21060	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 3 0 2005	32. Registrar's Sig	nature					

Ciffany S. Gomez Unpend item#23a,27,28a-1, perME, 6848,10-21-05 Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 05-6504 \KG Rog. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Tiffany Gomez September 23, 2005 1:30 P /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG 26, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 1 ☐ M 2 🗶 F 567-29-4579 Yrs. Director 43 1962 California Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or then "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at MD Cecil 1 ☐ Yes 2X No Rising Sun Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 311 Montgomery Road 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify. 3 ☐ Widowed 4 M Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 nd 2 should be filed value and Mental Hygie 27 is marked other if traumatic event, if other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Smith Deann Yonk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney Smith, daughter 301 N. Market Street, Apt. 2, Wilmington, DE 19802 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Peges 1 nent of H ant: If Ite 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ortant: I Metro Crematory, Inc. 09/27/05 Baltimore, MD Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 George E. MacNabb 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Drowning /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. East Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical inding pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant for u 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? rentificete he U Yes 2 No V Z Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No **2**ER/Outpatient 3 □ DOA 27. Manner of Death Fnd (Month, Day Year) 28d. Describe how injury occurred Subject drowned Certification: 28c. Injury at Work? Findhiury After 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 12:25 P^M 2 X Accident efter death | Director: / d in by the t 9-23-05 in pool 6 Could not be determined 3 Suicide 28f. Location (Street and Number of Bural Boute Number, City or Town, State) 1403 Buckthorn Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Pool 4 - Homicide ywithin 24 hours e... Jarrettaville, Md To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 24, 2005 0 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 KOREU 32. Pagistrar's Signature State 2005 Registrar

		1 - For State Registrar		Cen	tificate of	Death			200	ole. 05 31	717
Phys		1. Decedent's Name (First, Middle, La Janet Darle					2. Date of D Month Septer	nber	^y 22.	3. Time 2005 2:05	of Death
	dical niner	4a. Facility Name (If not institution, given 3619 Birdsville	ve street and number)			or Location of Death			. County o	of Death	
Funer	al	Social Security Number 6. 5	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of B	irth		9. Birthplace (State Country)	or Foreign
Direct	or	217-78-0243 Usual Residence of Decedent	1□M 2□XF	47 Yrs.	World Days	riouis iviii.	July (08 19	58	M[
after deeth with the Maryland or Items 23s or 28s-1 show in the must be notified at	ector	10a. State 10b. County Maryland Anne /	Arundel 10c. C	ity, Town or Loc		avidsonv	ille	10- 07		10d. Inside	City Limits s 2 ∑ No
th with 23a or	a D	3619 Birdsville	Road		101. Zip 0000	21035		Tog. Cit		SA SA	
after or fte	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (S pan, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	0-		- American Indian, k, White, etc. White	
and Mental Hygiene. Is marked other then "nature!", oumailc event, It's Medical Exa	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occu kind of work done O NOT use retire ECTETATY	during most of wor ed)	rking			siness/Industry	0 .
d other then event, it a Mis	Be	17. Father's Name (First, Middle, Last	0		<u></u>	18. Mother's Nar					<u> </u>
marke	၉	Denton Wolford 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Stree	Janice		her City o	or Town S	State Zin Code)	
other treumatic		Janice Wolford	(mother)	685	Duvall H	lighway, F					
: If item 27 I		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 [Removal from State		atory or other pla	. Jaepi	Date 26			City or Town, State	
Importent: If its any injury or o	j	4 Donation 5 Other (Special Signature of Funeral Service Lice			matory I	.110.	005	Ddit	, I mor	e, Maryla	na
0000				22.	Name and Addre	ess of Facility	Stallin	nas F	unar	al Homo	DΛ
Permit Pages 1 at Depertment of Hea Depertment of Hea Depertment of Hea Depertment of Hea Depertment of Hea Depertment of Hea Depertment of Heart Depertment of Heart Depertment Depertment Depertment Depertment Depertment	n al	23a. Pa 11. Enter the disease or containing the ck, or heart failure. List my Immediate Cause (Final disease or condition resulting in death)	p leations that caus . In As one cause on each line. Hypertensive Due to (or as a conse	Do not ente	111 MOUN	itain Roa(ing, such as cardiad	Pasac or respiratory	dena,		Approxim Interval B Onset an	ate etween
hysicia /Medic xamine	Examiner	shick, or heart failure. List mly Immediate Cause (Final disease or condition	a. Hypertensiv	Do not entered ather quence of):	111 MOUN	itain Roa(ing, such as cardiad	Pasac or respiratory	dena,	MD	21122 Approxim Interval B Onset an	ate etween
amine rusii	Examiner	Immediate Cause (Final disease or condition resulting in death) Sauntially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events	Due to (or as a consect.	Do not entered ather quence of):	111 MOUN	itain Roa(ing, such as cardiad	Pasac or respiratory	dena,	MD	21122 Approxim Interval B Onset an	ate etween
attending physicien and for use as the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sauntially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events	Due to (or as a consect.	Do not enter quence of): quence of): quence of):	111 MOUN	ntain Roac ing, such as cardiac tic cardi	Pasac or respiratory	dena,	MD disea	Approximinterval E Onset an	ate etween
attending physicien and in in in in in in in in in in in in in	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Saturation list condition resulting in death) Saturation list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consection of pregrative birth 2 Fet 4 Pregnant at time of pull unknown	Do not enter quence of): quence of): quence of): quence of):	111 Moun r the mode of dyi rosclero Ectopic pregnanc Other (specify)	ntain Roac ing, such as cardiac tic cardi	novascul	dena, arrest, ar	MD disea	Approximinterval E Onset an	ate stween I Death
seen signed by the attending physicien and hould be detached for use as the burial-transit	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Saturation list condition resulting in death) Saturation list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consection of pregrative birth 2 Fet 4 Pregnant at time of pull unknown	Do not enter quence of): quence of): quence of): quence of):	111 Moun r the mode of dyi rosclero Ectopic pregnanc Other (specify)	ntain Roac ing, such as cardiac tic cardi	Pasac or respiratory ovascul 23e. Did	tobacco u	MD disea 23d. Date Moni	Approximinterval E Onset an On	Year death?
ate hes been signed by the attending physicien and modern of the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sauntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a consection of pregrative birth 2 Fet 4 Pregnant at time of pull unknown	Do not enter quence of): quence of): quence of): quence of):	111 Moun r the mode of dyi rosclero Ectopic pregnanc Other (specify)	ntain Roac ing, such as cardiac tic cardi	23e. Did	tobacco u	23d. Date Moni	Approximinterval E Onset an Onset an Day	Year death?
ate hes been signed by the attending physicien and pege 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sa united list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregrant at time of go Unknown contributing to death but not re	Do not enter quence of): quence of): quence of): quence of): ancy al death death sulting in the unit	T11 Moun in the mode of dyi cosclero Ectopic pregnanc Other (specify)	ey ven in Part I. 26. Place of Dea	23e. Did 1 24a. Wa auto per la	tobacco u Yes 2 s an younger 2 No one	23d. Date Mont	Approximinterval E Onset an On	Year death? inknown s available cause of
ste hes been signed by the attending physicien and B B B B B B B B B B B B B B B B B B B	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sauntially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Pa III. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Wastural 5 Pending investigation	Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown contributing to death but not re Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	Do not enter quence of): quence of): quence of): quence of): ancy al death death sulting in the unit	Ectopic pregnanc Other (specify) _ derlying cause gr	ven in Part I. 26. Place of Deather:	23e. Did 1 24a. Wa auto per la	tobacco u Yes 2 Yes 2 No one)	23d. Date Mont	Approximinterval E Onset an On	Year death? inknown s available cause of
hy a constraint of the strength of the strengt	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sa unitely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregration of the program of the pro	Do not enter re ather quence of): quence of): quence of): quence of): sulting in the unit 28b. Time of Injury nome, farm, stre	Ectopic pregnance Other (specify)	ven in Part I. 26. Place of Deather: 4 \(\triangle \tr	23e. Did 1 24a. Wa auto per 1 1 2 2 2 2 2 2 3 2 2 3 2 3 3 3 3 3 3 3	tobacco u Yes 2 Yes 2 No one) iidence (how injur (Street an own, State	23d. Date Month of State of Number o	Approximinterval E Onset an On	Year death? Inknown s available cause of
ote hes been signed by the attending physicien and Medica been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sauntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregration of	quence of): quenc	Ectopic pregnanc Other (specify) derlying cause gri 28c. Inju Wo M 1 et, lactory, office	tain Roading, such as cardiad tic cardial	23e. Did 23e. Did 1 24a. Wa auto per 1 24a. Wa (Check only) 28d. Describe 28f. Location City or To	tobacco u Yes 2 S an oppsy 2 No one) idence (Street an own, State	23d. Date Mont use contrib 24b. W pr de de de de de de de de de de de de de	Approximinterval E Onset an Interval E Onset a	Year death? Inknown s available cause of
e law requires that the death certificate be executed a x been signed by the attending physicien and pe 2 should be detached for use as the buriat-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sauntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown contributing to death but not re 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - Att building, etc. (Spec	quence of): quenc	Ectopic pregnanc Other (specify) _ derlying cause gr 28c. Inju Wo M 1 _ et, lactory, office occurred at the trestigation, in my office 29c. License	tain Roading, such as cardiad tic cardial	23e. Did 23e. Did 1 24a. Wa auto per 1 24a. Wa (Check only) 28d. Describe 28f. Location City or To	tobacco u Yes 2 S an one) idence (Street an own, State e cause(s), date and	23d. Date Mont use contrib use contrib 24b. W pr de de do Nother ry occurre and Number and place, ar te signed	Approximinterval E Onset an Interval E Onset a	Year death? Inknown s available cause of

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrer Certificate of Death Reg. 2005	31718
		1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
Physici /Medic	al	Maxine Kay Holliday September 2/,2005	8:15 p M
Examin	er	501 Academy Ave. Owings Mills Baltimor	·e
Funeral Director		5. Social Security Number 6. Sex 1 M 2 NF 7. Age (In yrs. last birthday) 1 Months Days Hours Min. Whin. Worth, Day, Year) March 30, 1948 9. Birth (Month, Day, Year) March 30, 1948	place (State or Foreign htry) WV
yland		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1	0d. Inside City Limits
Ba-fs	ctor	MD Baltimore Owings Mills	1 □Yes 2X No
with the	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cour	itry?
death	nera	501 Academy Ave. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, Specify Cuban, Mexican, Puerto Rican, etc.)	
IOFE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. It filem 27 le marked other than "nature", or Items 23c or 28a-f show or other traumatic event, the Marical Examinations Items 11c rediffed to	b	3 □ Wildowed 4 □ Divorced If Yes, Give □ 1 □ Yes 2 M No Specify: Specify: Specify:	White
21215-0036 ad within 72 hours aff gjene. er than "natural", or er, the We Jigal Exami	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/In	dustry
within iene.	omp	Elementary/Secondary (0·12) College (1·4or 5+) 11 College (1·4or 5+) Housewife Own Hot	ne
tnd 2 be filed ttal Hygi d other event,	BeC		
Maryland Id 2 should be file Ith and Mental Hy Ith and marked oth Traumatic event	Jo.	Grover G. Hunter Margie Lee Crookshanks	
Mar od 2 st Ith and 27 le n		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural Route Number, City or Town, State, Zip</i> Russell L. Holliday Husband 501 Academy Ave., Owings Mills, MD 21117	
ore, M es 1 and 2 of Health litem 27 I		20a. Method of Disposition 20b. Place of Disposition (Name of Campillary Committee) 20c. Location - City or To	
Baltimore, bernit. Pages 1 ar Department of Hea mportant: If item any injury or other these.	L,	'4 □Donation 5 □Other (Specify) Grace Cemetery 10/3/05 Reisterstown	ı, MD
Baltimol permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reistersto	
* **		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	21136 Approximate Interval Between
Physician	p II	Immediate Cause (Final disease or condition Amatoria Later Schools Consists	Onset and Death
/Medical Examiner		resulting in death) Due to (or is a consequence of):	
outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate out that underpression of the control	
icate be executed physician and sthe burial-transit			
Box 6 death certif	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant	ery Day Year
v s un e	by	Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.	ne cause of death?
() > 00	ompleted	1 Yes 2 No 3 Prot	psy findings available
I Rec	ошо	autopsy performed? The performed The perf	mpletion of cause of
f Vital F ysician: Th is certificate director, pag	BeC	© 25. Was case referred to medical 28. Place of Death (Check only one)	20110
- × · · · · · · · · · · · · · · · · · ·	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific	v)
	ertification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	
E Pite	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)	I Route Number,
چ ڌ ڪ ٽ	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to and manner stated.	tated. the cause(s)
To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	Day, Year)
2		Kachum Wore D0053712 Sept 28.	2005
\mathcal{I}		Kathan Wash MD, JHH, 600 N. Wolfe St., Balt MD	X.8515
	ate	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist	÷.		
		ORIGINAL	

			1 - For State Registrar	State of Ma	ryland / Depa	artment of H			000-	
	_		Registrar 1. Decedent's Name (First, Middle, Las	21	Cei	illicate of t	Jealli	2. Date of Death	1. No. 2 U U 5	31719
	Physicia	an		,,,	HARER	ME		Month	Day Year	3. Time oppeatin
	/Medic		4a. Facility Name (If not institution, give	street and number)	4,112		Location of Death	SEPTEMBER	4c. County of Death	1649 P M
	Examin	er		HOSPITAL			MUTOW N			
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	RALTIM 9. Birth	piace /Ctate or Femine
	Director		219-78-8379 1	X M 2□F	47 Yrs.	Months Days	Hours Min.	(Month, Day, Y	earl Cou	intry)
	p .		Usual Residence of Decedent		10.00.7		·			
	aryla shov	-	10a. State 10b. County		10c. City, Town or Lo	cation	.1.			10d. Inside City Limits
	he M	ecto		MORE		atons	1.11e			1 ☐ Yes 2 No
	with t	급	10e. Street and Number	al. D	1	10f. Zip Code	12.1.1	100	Citizen of What Cou	intry?
	s 23	erai	1705 Cheste	12. Was Decedent E	CI.	Was Doordoot of U	1244	and Van as Na	14. Race - Amer	iona Indian
	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show A dical Examinat nout be rediffed at	Funeral Director	1 Never Married 2 Married	Amed Forces?		Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White	
936	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	ack.
215-0036	2 ho	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Business/li	ndustry
218	within 7 ene. than "r	ple	(Specify only highest gra	College (1-4or 5-	lite	kind of work done of OO NOT use retired	during most of won	king	. /	
7	ed wi	Con	NA			mploye			N/4	
Ind	be filed within 72 hours after death with the Marylan ttal Hygiene. od other then "natural", or flams 23a or 28e-f show other then "natural", or flams 23a or 28e-f show event, the Medical Examiner must be motified at	Be	17. Father's Name (First, Middle, Last)	11	4		18. Mother's Nam	e (First, Middle, Ma	niden Surname)	1
yla	thould by the marked marked marked	P	Raymond L		AVE		Lauro	i Mel	Ulloug.	h. 21228
Maryland	s t and 2 should f Health and Men item 27 is marke othar traumatic		19a. Informant's Name/Relationship (Type, Pnnt) T	196. Mailii	ng Address (Street a	4.1	1. 10	City or Town, State, Zi	p Code) 21228
-	item 2		20a. Method of Disposition		20b. Place of Dispo	Sition (Name of		Date 20	C. Location - City or T	Own State
nor	0 = 5		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif			matory or other plac				
Baltimore	permit. Pa Departmen Importent: any Injury		21. Signature of Funeral Service Licer		Woodlau	2. Name and Address	ss of facility 22	100 J	ALTIMOR	N MD 21093
B	permi Depa Impo any Ir		Kimber Isel	Ballac						EMATION CIT
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate
	Physician		Immediate Cause (Final	•	lebsielle					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		consequence of);	sepus				deign
ı	Examiner		Sequentially list conditions,	b. Dre	anones w	ith resp	intoy 7	allere		dom
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):	./	00			
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	0	He rend	falle	re			days
60,	be ex cian a	E	Tooling in dodiny and	Due to (or as a	consequence of):	U				-
8760	icate be executed physician and s the burial-transit	edlcai		d			· · · · · · · · · · · · · · · · · · ·			
×6		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of deliv	1001
Вох	death certii e attending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			Month Month	Day Year
o <u>i</u>	at the de by the a tached	nysi	1 Yes 2 No 9 Unknown	9□ Unknown						
Д,	The law requires that the ttp has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	w require been sig should b							1 ☐ Yes	2 □No 3 □ Pro	bably 4 Dinknown
900	e law re has be	ompieted						24a. Was an	24b. Were aut	opsy lindings available
H	The late has page	mo;						autopsy performe	d? death?	ompletion of cause of
Vital	siclan: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only one)		
of V	Physiclan: this certific ral director,	To.	1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpatier		4 Nursing Ho	ome 5 Resident	ce 6 ☐ Other (Speci	Try)
n	on 0 0	inol	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	Work		28d. Describe how	injury occurred	
sio	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 No	201 1 121		
Division	al or Attendin after death. I Director: Aft d in by the fur	Certification:	4 ☐ Homicide determined	building, etc	ry - At home, farm, str . (Specify)	reet, factory, office		City or Town,	et and Number or Rur State)	al Route Number,
	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowledge deat	h occurred at the tim	e date and place	and due to the caus	se(s) and manner as	etatod
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or in	vestigation, in my or	pinion, death occur	red at the time, date	and place, and due t	to the cause(s)
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in b	Me	29b. Signature and title of certifier			29c. License	e number	29d	. Date signed (Month,	Day, Year)
	· N.		Queter	mo.		D	005973	6 1	1	16 2005
!	1/		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,			در ا	uptenber 2	
			DEBURAH WA-		NURT	HWEST 1	403 PITAL	5401	OLD COUR	T ROAD
	Sta Registr		31. Date filed (Month, Day, Year)	0.7	r's Signature	John				
	negisti	ul .	SEP 3	0 2005	Balled State					

			For State Registrar	State of Ivial			tificate of		R	00 NE 0 0 5	31720
	hysicia		1. Decedent's Name (First, Middle, Last Jessie Maxine						2. Date of Deat	n Day 27 Yee	3. Time of Death
	/Medic xamin		4a. Facility Name (If not institution, give Upper Chesapeake		ımızıı t			or Location of Dea		4c. County of De	eath
Fu	neral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days		S. 8. Date of Birth		tirthplace (State or Foreign Country)
	ector		171-18-9376 1L Usual Residence of Decedent	M 2√2 F 8	9	Yrs.	Works Duys	Thous will	n. B. Date of Birth (Month, Day)	, 1915 Pe	nnsylvania
ıryland	d at		10a. State 10b. County		10c. City, To						10d. Inside City Limits 1 ☐ Yes 2X No
the Ma	Coulifie	recto	PA Warren 10e. Street and Number		В	ear I	10f. Zip Code		1	0g. Citizen of What	
th with	23a or	ai Di	27 Centre Street					16402			S.A.
d Z I Z I 3-0030 filed within 72 hours after death with the Maryland Hygiene.	is marked other than "natura", or items 23s or 28s-1 show reumstic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Endemed Forces? 1 Yes 2 No lf Yes, Give Year or Dates:			Vas Decedent of P Yes, specify Cub ☐ Yes 2 🕱 No		(Specify Yes or No- arto Rican, etc.)	14. Race - Ar Black, Wi Specify: (
22 ho	natura diset E	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	10	6a. Deced	ent's Usual Occup kind of work done OO NOT use retire	pation during most of w	rorking	16b. Kind of Busines	ss/Industry
within jene.	r than	ошр	Elementary/Secondary (0-12)	College (1-4or 5+	-1		sed Prac		i i	Medic	ine
d be filed ental Hyg	evant,	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle, i Anderso		
should brown brown	marka	၉	PLynn Yeany 19a. Informant's Name/Relationship (T)	ype, Print)	1	I9b. Mailin	g Address (Street			r, City or Town, State	a, Zip Code)
<u>글 및</u> 돌	1 tr		Mrs. Frances Ensl	in (daught					Baltimor		236
ages 1	: If itam or otha		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 1				sition (Name of natory or other pla			20c. Location - City	
Department of H	oortant / injury 28.		4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens		151.					Funeral H	, Maryland omes
n &a.	E # 8		Ma	let		9:	105 Bela	ir Rd.,	Baltimore	, MD 2123	6
	sician edical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a	5	e p	S 1 S	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	niner			Due to (or as a	co equen	ce of):	ated	Duoden	WILL A	X	2 clays
(<u>1</u> 2	sit	iner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	neupeenco	ea of):					
os/bu, f	physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequen	ce of):					
68/6U ; ificate be ex	hysicia the bur	dical		d							
Geath certif	by the attending patached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t	2 ☐ Fetal de	ath 3□	Ectopic pregnand Other (specify)	y		23d. Date of o	delivery Day Year
S, F	gned se de	by Ph	Part II. Other significant conditions co	ontributing to death bu	t not resultin	ng in the ui	nderlying cause gr	ven in Part I.			to the cause of death?
ecords,	been sig		024	on by			<u></u>		1 Y		Probably 4 Unknown
r å	certificate has birector, page 2 s	Completed	P (0)			WTT	100			sy prior t med? death 2⊠ No 1 □ Y	
r VITAI ysician:	O 10	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \)	Hospital:	nt 2 ER	/Outpatien	t 3 DOA Ot	hae	eath <i>(Check only or</i> Home 5 \to Reside	ence 6 Other (S	pecify)
ISION Of Attanding Physical death.	or: After th	Certification: 7	27. Manner of Death Matural 5 Pending investigation	28a. Date of Injun (Month, Day		b. Time of Injury	28c. Inju Wo M 1	ny at nk?] Yes 2 □ No	28d. Describe h	ow injury occurred	
DIVISION or Attanding after death.	Diractor: I in by the	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home . <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location (S. City or Tow		Rural Route Number,
DIVISION Of VITA To the Hospital or Attanding Physician: within 24 hours after death.	To the Funeral Director: completely filled in by the	Medical C		ysician: To the best o iner: On the basis of and manner stat	examination						
To tl	Tot	S	29b. Signature and title of certifier	P. amos	b		Do	se number	5	Deplember	onth, Day, Year) x 28, 2005
	H		30. Name and address of person who	ompleted cause of de	ath (Item 23	Sa) (Type,	Print) Ur. U	relard	r. Amoss	F401.	,

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 3 0 2005

9/27/05

#434364

HOTCHKISS, JESSIE

32. Registrar's Signature

			For State Registrar	State of M	arylan		artment of H		and Mental		2005	31721
ľ	Physici		1. Decedent's Name (First, Middle		101	UT			Man	of Death	Day Year BER 28 24	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, or	Location o			4c. County of Dea	ith
			MANOR 5. Social Security Number	CARE 7. Ac	no (Im uma	last birthday)	Tous If Under 1 Year	If Under:	24 Hrs o Day	of Dieth		IMORE
	Funeral Director		212-42-1343	1 X M 2 □ F	54	Yrs.	Months Days	Hours		of Birth 797	arı c	thplace (State or Foreign ountry) th Carolina
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ecation					10d. Inside City Limits
	a-f sho	to	MARYLAND N/A		Balt	imore						1X Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 26 North Miltor	n Avenue			10f. Zip Code 21224			-	Citizen of What C ited Stat	•
920	I within 72 hours after death with the Maryland ifen. ifen. Then."natural; or items 23e or 28e-f show the Medical Exambre must be notified at	þ	11. Marital Status XXNever Married 2 Marr 3 Widowed 4 Divorced	If Yes Give	?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	ispanic Origin, Mexican	gin? (Specify Yes , Puerto Rican, e	or No-	Specify	
21215-0036	within 72 ho iene. than "natu	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or	5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	ation during most	t of working		. Kind of Business	
d 21	Hys ht.		17. Father's Name (First, Middle,	Last)		Paint	ter	18. Mothe	r's Name (First, M		onstruct: den Sumame)	ion
Maryland	ed its b	То Ве	Howard Hunt						lian Oxe		,	
Mary	s 1 and 2 should f Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relations				ng Address (Street					
d)	of Health		Hilton P. Hunt / 20a. Method of Disposition			lace of Dispo	Milton A	1	Date Date		Marytand . Location - City or	
imo	Pages nent or ent: if I		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State ipecify)		•	natory`or other place Cemetery		0/01/200	5 Ba.	ltimore,	Maryland
Baltimore,	permit. Pages of Department of Himportent: If Ite any injury or of once.		21. Signature of Funeral Service	icensee 1.211	in							al Homes PA yland 21231
			23a. Part1. Enter the disease, og shock, or heart failure. List Immediate Cause (Final	only one cause on each I	ine.				cardiac or respira	itory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as b. Due to (or as	care a consequ	uence of):	h Tare 1					Minutes
	Cxammer	L O	Sequentially list conditions,	b. Corona	a consed	41 tery	Discase					years
b	cuted od ranslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. D19								Yeavs.
8760,	sician ar buriai-t	icai Ex	resulting in death) Last	Due to (or as	a consequ	uence of):						
89	ntificate ng phy s as the		IF FEMALE:	0.								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by line tuneral director, page 2 should be detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	I death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
S, P	ss that gned b	by Pt	Part II. Other significant condition		,		nderlying cause give	en in Part I.	23e	. Did tobacc	co use contribute t	o the cause of death?
ord	require een się hould b	ted	Periphera	1 Vuscular	2/1300	450				Yes	2 □ No 3 □ P	robably 4 □Unknown
Il Records,	: The law cate has b	Completed								. Was an autopsy performed Yes 2	? prior to death?	utopsy findings available completion of cause of
Vital	sician certifi rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		FD/0-4	Oth		of Death (Check		a Clou	
n of	ing Phys After this uneral di		27. Manner of Death 1 SNatural 5 □ Pendin	28a. Date of Injury		28b. Time o Injury	f 28c. Injun Worl	y at k?	28d. Des		6 Other (Spenjury occurred	ecify)
Division	or Attend fler cath lirector: / n by the f	Certification;	2 ☐ Accident investi 3 ☐ Suieide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of In	ijury - At ho tc. <i>(Specin</i>)	ome. farm, sti	M 1 1	Yes 2⊡I	28f. Loca	ation (Street or Town, St		ural Route Number,
	Hospital	Medicai Ce	29a. Certifier 1 Certifyir (Check only one)	ng Physicien: To the beside Exeminer: On the basis of	of examina	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, and due th occurred at the	to the cause	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 Fo the comple	Mec	29b. Signature and title of certifie				29c. License	e number		29d.	Date signed (Mon	th, Day, Year)
	7) Joson	Black	me	2	200	6119	9	Se	pt 29	2005
	6		30. Name and address of person Jason Black	mo 656	5 M	0174	Charles s	57,5	cute 20	3 70	usen m	021204
	Sta Registi		31. Date liled (Month, Day, Year) SEP 3	32. Regis	rar's Signa	ture	Sparke					

State of Maryland / Department of Health and Mental Hygienes 31722 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Miriam Alice Hetzel September 27 2005 9:30P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health Care Catonsville Baltimore If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F 186-16-6231 92 Yrs Director 1912 Pennsylvania Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "neturel", or iteme 23a or 28a-f shov tre Medical Examiner must be notified at 1 Yes 2X No Woodlawn Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1122 Baker Avenue 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Social Security nd 2 should be filed vilth and Mental Hygie 27 te marked other ir traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blance Thompson Alice Seymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Randall E. Hetzel (Son) 1122 Baker Ave. Baltimore, Maryland 21207 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Crestlawn Memorial Gardens 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment o important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 10-1-2005 Marriottsville, MD 21. Signature Service Licensee 22 Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 110/290 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Completed by Physician/Medical ed by the attending physideteched for use as the IF FEMALE: 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II., Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an YROIDISM pege 2 s autopsy performed? (es 2/2)No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Fo the Hospital or Attending Physician: : After this certification of the thick the th 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification; To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide within 24 hours after de To the Funerel Directo completely filled in by the Ptace of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number D18362 MP. of death (Item 23a) (Type, Print) Batto, Md2/22 Suite 308. 3455, Wilkens Ave KOMalk. Dang 31. Date filed (Month, Day, Year) SEP 3 0 20 39. Registrar's Signature State Registrar

			For State Registrar	State of Marylar	•	artment of H tificate of L		and Me		ne 2005	5 31723
ı	Physicia		1. Decedent's Name (First, Middle, Last) Douglas Johns	1001					Date of Death Month	Day The Ye	
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of		FILEHOUN	4c. County of D	
	_xa,	Ģ.	Northwest Hospita	1 Center		Randal:	lstow	n		Balti	more
П	. Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day, Y	ear) 9.	Birthplace (State or Foreign Country)
	Director		219-42-6/41	62	Yrs.				ine 21,	1943	Maryland
	and w	}	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	MD Baltimore		Point	omatorm					1 ☐ Yes 2 ☒ No
	the 28a-	Director	10e. Street and Number		Keist	erstown			10g	. Citizen of What	t Country?
	3a or		393 Butler Roa	ıd		21	136			U.S.A.	
	deati	Funeral	11. Marital Status	. Was Decedent Ever in U Armed Forces?	.S. 13. \	Vas Decedent of Hi f Yes, specify Cuba		gin? (Specif		14. Race - A	American Indian, Vhite, etc.
õ	hours after death with the Maryland turel; or Itams 23a or 28a-f show al Exactinet must be notified at		1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		Tos, specify cuba		, 1 40/10 7 110	Mai 1, 010./	Specify:	vinte, etc.
9500-6121	ural',	d by	3 Widowed 4 Divorced	Year or Dates:							White
7	"nati	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired,	ation <i>luring mosl</i> 1	t of working	16	b. Kind of Busine	ess/Industry
7	filed within Hygiene. Ither than "	шс	Elementary/Secondary (0-12)	College (1-4or 5+)		inist	,			Rlack a	nd Decker
0	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel; or Itams 23a or 28a-f show or other than "naturel; or Itams 23a or 28a-f show evant, Ita Medical Examiner must be notified at	Be Co	17. Father's Name (First, Middle, Last)		Traci	THISC	18. Mothe	or's Name (F	First, Middle, Ma		nd becker
Maryland		To B	Richard	Johnston			Fra	nces		Unknown	
a	de la la		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	g Address (Street a	and Numbe	or or Rural R	loute Number, C		e, Zip Code)
	1 and 2 Health a nm 27 is		Leslie Johnston	Wife	393 E	utler Roa	ad R	eister	stown,	Marylan	d 21136
altimore,	of F		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ Rer		Place of Dispo	sition (Name of natory or other place	θ)	Date	20	c. Location - City	or Town, State
Ĕ	Pages ment of ant: If it ury or o		'4 □ Donation 5 □ Other (Specify)		rroll (remation	Ser.	9/30/	′05 E	lampstea	d, Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	0. 11-		. Name and Addres		. 110		terstown	
_	<u></u>		slephen M	Jenken		INE FUNE					
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the dea cause on each line.	th. Do not ent	er the mode of dying	g, such as	cardiac or re	espiratory arrest	,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	50	EP515-						
	/Medical Examiner			Due to (or as a consec			_				
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	HEPATOREN Due to (or as a consec	juence of):	MHORAME	SE	CENOA	Ry To	SE 1 S10	>*
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	COASTRO IN	TEC -T	0	SLEE	^			
<u>,</u>	exection and training the second and	Еха	that initiated events c. resulting in death) Last	Due to (or as a consec		INIT	Jene				
8/60	cate be executed obysiclan and the burial-transit	dical	d.								
٥	rtifica ng ph		IF FEMALE:								
ROX	death certific e attending p id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 		Ectopic pregnancy				23d. Date of Month	
O. II	e dea the at	sic	1 Yes 2 No	4 Pregnant at time of of 9 Unknown	death 5□	Other (specify)				MORITI	Day Year
٦.	w requires that the deben signed by the should be detached	Phy	Part II, Other significant conditions contr	ibuting to death but not res	culting in the u	dorhina cauca awa	o in Part I		23e Did tohac	co use contribut	e to the cause of death?
S,	signe signe	l by	, are in other origination of the	loating to doubt but not re-	ditting in the ti	idenying cadse give	nini aiti.				Probably 4 Nunknown
Vital Records,	r requ	Completed									/
ě	The law ate has boage 2 st	mpl							24a. Was an autopsy performe	prior	autopsy findings available to completion of cause of n?
2		e Co	25. Was case referred to medical						1 Yes 2		/es 2 No
	sicia certi	o Be	examiner?	spital: 1/☑Inpatient 2□	ER/Outpatien	t 3 DOA Othe			heck only one)	e 6 □Other (S	Pagaiful
ō	y Phys er this eral dir		27. Manner of Death	28a. Dale of Injury	28b. Time of	28c. Injury	at		I. Describe how		вр ес пу)
DIVISION OF	nl or Attanding Pafter death. Diractor: After t	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	?? Yes 2 ☐ i	No			
VIS	Atta er dea racto by th	tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f.	Location (Stree		Rural Route Number,
$\bar{\Box}$	tal or A rs after al Dirac ed in by	Cer		Saliding, Ote. (Special							
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examina	r: On the best of my knor: On the basis of examina	owledge, death	occurred at the time	e, date and	d place, and th occurred	I due to the caus at the time, date	e(s) and manner and place, and	r as stated. due to the cause(s)
	the I	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				Date signed (M	
	Z wit			while me	>	DYIU			1	Plantoz	a ch such
	KA		U A		- 20-) 7			M 4		4 ~ MACK	21/2013
	15		30. Name and address of person who com	A	A				HTA 9	31133	
	Sta	te	31. Date filed (Month, Day, Year)	339Registrar's Sign	ature	MANCALL	5 101	dN	MO 3	111 22 4	
	Registr		SEP 3 0 2005	32 Registrar's Sign	7 00	whi !					
72-	negisti			9							

Box 68760,
, P.O.
Records
f Vital
Division o

		For State		f Maryland	Depa		of He	alth a		lental Hyg	iene		0.1.70.1
		Registrar 1. Decedent's Name (First, Middle, I	local		Cel	lincale	OI D	eain		2. Date of Dea	eg. 1 2 2. ()	U5	3 1 124
Physicia	an									Month	Day	Year	3. Title of Death
/Medic	16	Mildred Marie K 4a. Facility Name (If not institution, g		mborl		4b. City, To	our or L	onation o	f Doath	09		2005 unty of Death	4:00 PM M
Examin	er			moeri				ocation o	Death				ı
(1879) X	Total 1	1611 Stoneridge 5. Social Security Number 6	Way Sex	7. Age (In yrs. last	hirthday)	Bel If Under 1	Air Year	If Under a	24 Hrs.	8. Date of Birth		rford	polace (State or Foreign
Funeral Director			1 ☐ M 2 🏋 F	79	Yrs.			Hours	Min.	(Month, Day	, Year)		nplace (State or Foreign untry)
Director	-	216-20-4167 Usual Residence of Decedent		19		<u> </u>				12/23/1	925	VIZ	ryland
land low		10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
Man	to	MD Harfo	ord	Bel	Δir								1 □Yes 2 No
death with the Maryland ms 23a or 28a-f ehow r must be froitfind at	Director	10e. Street and Number	71.0		4444	10f. Zip (ode				0g. Citizen	of What Co	untry?
138 o		1611 Stonerido	ve May			210	015				U.S.	Δ	
deat	Funeral	11. Marital Status		edent Ever in U.S.	13.			anic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
after or ite	F	1 Never Married 2 Married	d 1 □Yes	2 X No	1	1 🗆 Yes 2	_	Specify:	, , , ,	, mouri, oto.,		ecify:	5, 810.
be filed within 72 hours after ital Hygiene, od other then "natural", or ite event, the Medical Exantor	d by	3	If Yes, Gi Year or D	Pates:		10.00		ороолу.				Wh	ite
72 h 'natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)	1	(Give	dent's Usual kind of work	done dur	on ring most	of work	ing	16b. Kind o	of Business/I	ndustry
hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)						
lygier her ti	S	12	net)		Hon	nemakir	ng	9 Motho	r'e Nam	e (First, Middle,		Home	
be fi	Be	17. Father's Name (First, Middle, La									walden Sui	namoj	
should ind Men marke umatic	2	Charles W. Chet			Ob Maili	na Addense /		Edna		rten al Route Numbe	City or To	um Stato 7	(in Code)
12 st h and 7 te n traun		19a. Informant's Name/Relationship				2007 Section 5 100							ip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other then "natural", or items 23s or 28s-1 ehow any injury or other traumatic event, the Mudical Examinat must be notified at once.		Diane M. Hollow 20a. Method of Disposition	vay (daug	ghter)	1611 e of Dispo	Stone osition (Name	erido	ge Wa	ay -	Bel Air		yland ion - City or	21015 Town, State
Pages nent of thint: If ite		1 X Burial 2 ☐ Cremation 3		State		osition (Name matory or oth			- 1			•	
nit. Pa partmen ortant; injury		4 □ Donation 5 □ Other (Spe		Park		Cemet							Maryland
permi Depa impo any ir		21. Signature of Funeral Service Lin	censee	Tham =									l Home, P.A.
40200		wether pe	25000C	MAIN		_				- Kingsv		Mary.	land 21087 Approximate
		23a. Part1. Enter the disease, or conshock, or heart failure. List or	nly one cause on	each line.	o not en	ter the mode	dying,	such as	Cardiac	d A A A A A	est, ;		Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a	CANOT	AC	/ /	Ne	ni,	170	MIA			
/Medical Examiner		resulting in death)	Due to	(or as a gonsequen	co of):	115	\						Mark
*	٠	Sequentially list conditions,	b	(or as a consequen	00 C	Vb							1 7
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dueto	(OI as a collsequen	Ca OI).								
execut an and rial-tran	хап	that initiated events resulting in death) Last	c	(or as a consequen	ce of):	-							
Du Se	cai E												
icate phys s the		Y	d										
The law requires that the death certifica tte has been signed by the attending phr bage 2 should be detached for use as th	Physician/Medi	IF FEMALE:	23c. If yes, ou	itcome of pregnancy	,						23d	. Date of deli	verv
atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 ☐ Fetal de nant at time of deati	ath 3	☐Ectopic pre☐ Other (spe					200	Month	Day Year
that the de ad by the detached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkr										
res that the igned by be detact		Part II. Other significant condition	s contributing to	death but not resultin	ng in the u	inderlying ca	use given	in Part I		23e. Did to	bacco use	contribute to	the cause of death?
uires sign Id be	d by									1 □ Y	es 2 🗆 N	lo 3 Pr	obably 4 Unknown
w requir been s should	Completed									24a. Was	an 2	4b Were au	topsy findings available
The lavate has	를									autop perfor	sy ,	prior to death?	completion of cause of
10 -	Ö	25. Was case referred to medical					,	OC Place	ad Dane	1 ☐ Yes	ZINO_	1 Li Yes	2 No
Attending Physician; or death. ector: After this certific by the funeral director.	0 0	examiner?	Hospital:	Inpatient 2 ER	/Outpatie	nt 3 DO	Other			h Check only o	-	Other (Sec	7.64)
Phy ir this aral d	⊢	27. Manper of Death	-		b. Time o	4/100	lc. Injury a Work?		ising ric	28d. Describe h			лу)
ading th: : Afte	ig ig	Natural 5 ☐ Pending 2 ☐ Accident investiga		nth, Day Year)	Injury	М		es 2 🗌	No				
Atter dea ctor	fica	3 ☐ Suicide 6 ☐ Could no	ad 286. Plac	e of Injury - At home	e, farm, st	reet, factory,	office					umber or Ru	ıral Route Number,
after after Directory	Certification:	4 Homicide determin	build	ding, etc. (Specily)						City or Tow	n, State)		
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director.				e best of my knowle									
n 24 in Period	Medical	(Check only 2 Medical E		basis of examination nner stated.	and/or ir	vestigation,	in my opir	nion, dea	in occur	red at the time, o	ate and pla	ace, and due	to the cause(s)
To the within To the Comp.	Σ	29b. Signature and title of dentities	ARALI	12-1)	29c.	License I	number	. he		29d. Date s	igned (Monti	h, Day, Year)
			Miller	1000			リー	10	170)	011	110	(0)
0,		30. Name and address of person w	no completed cau	ise of death (hem 23	(Туре	Print)	7.	1		4.0	7 17	810	
10		7505 05	12N	1900 3		100	20	ν.	1	10)	616	04	•
Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signature	Θ ′	1 4	4						
Regist	rar	SEP 3	0 2005	Propose J	Con 1	Spare.							
					-	a.C.							

			For State Registrar		,	State o	of Mary	/land	Depa	artment of H	lealth Death	and Me		gie j e Reg. No.	005	31725
	Physicia	an	1. Decedent's Nam Kenn		N.	ŀ	(eys						2. Date of De Month Septem	Day	.7, 2005	3. Time of Death 5:45 p ^M
	/Medic Examin		4a. Facility Name (If not institution	on, give str	reet and nu	ımber)			4b. City, Town, o	or Location				County of Death	J. 13 P
			Greater 1		-	edica				Towson				E	altimor	e
	Funeral Director		5. Social Security N 212-20-0		6. Sex	M 2□F	7. Age (Ir	n yrs. last B2	birthday) Yrs.	Months Days	Hours Hours	B 41	8. Date of Bir (Month, Da ED LENDEI	th iy. Year) 10.	9. Birthr Cour 1923 Mary	place (State or Foreign Tand
	D D		Usual Residence o	f Decedent												
	death with the Maryland ims 23a or 28a-f ∎how ir must be notified ≇t	ctor	10a. State MD	10b. Count Ba	y ltimo	ore	10	_	OWN OF LO						1	0d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	I Dire	10e. Street and Nu		on Pi	lace				10f. Zip Code 21 20	4			_	en of What Cour	ntry?
1eH	ours after death with the Manylar elf, or itams 23e or 28e-f ehow Exemitier must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Man 3 ☐ Widowed		rried	2. Was Dec Amed F 1 X Yes If Yes, G Year or I	orces? 2 ∐ No ive		L	Was Decedent of H I Yes, specify Cub I ☐ Yes 2 No			cify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify:	
ehr 1215-00	within 72 ho sne. than "natur	ompieted	(Spe	15. Decede cify only high ondary (0-12)	est grade	completed,) (1-4or 5+)	1	6a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during mo d)	ost of workin	ng	Flo	uers/ Se Loyed	
λ	2 should be filed is and Mental Hygie is marked other reumatic event.	To Be Co	17. Father's Name	(First, Middle	, Last)		Keys	, Jr			_	ner's Name dna	(First, Middle May	, Maiden		ıh
Mary	s 1 and 2 should I Health and Mer Item 27 is marke other treumatic		19a. Informant's N							og Address (Street					Town, State, Zip	Code)
el nore,	permit. Peges 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre-		20a. Method of Dis 1 🔀 Burial 2 4 🗆 Donation	sposition	3 □Re		State	20b. Plac	e of Dispo etery, crei	sition (Name of natory or other pla	ce)		ate	20c. Lo	cation - City or To	
Ke_0	permit. P Departme Importan eny injur		21. Signature of F			• Wil	liam	G. D		Name and Addre					neral Ho 204	me, Inc.
	Physician		shock, or he Immediate Cause	art failure. Li: (Final	or complications on the contract of the contra	e cause on	each line.			er the mode of dyi	_	s cardiac o	r respiratory a	ırrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or conditi resulting in death)		C a.	Due to	(or as a c	onsequer	or y	Failu	. , (
8760, <	The law requires that the deeth certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	S	6. d.	Due to	o (or as a co	onsequer	nce of):							
P.O. Box 68760,	ihe deeth certifical / the attending ph. ched for use as th	Physician/Me	IF FEMALE: 23b. Was deceded in the past 1: 1 Yes 2 9 Unknow	2 months?	23		birth 2 onant at time	Fetal de	ath 3[]Ectopic pregnanc] Other (specify) _	у			2	3d. Date of deliver	ery Day Year
ords, P.	v requires that the de been signed by the a should be detached f	Ď	Part II. Other sign			_			-	nderlying cause gr	1	east		tobacco u		he cause of death? pably 4 Dunknown
Division of Vital Records,	sicien: The law respectively as the secretary page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 2 shirector, page 3 shirector, pa	Completed									_			an psy ormed? 2 2 No	24b. Were auto prior to co death? 1 \(\text{Yes}	opsy lindings available impletion of cause of 2007 No
Vita	icien: certific ector,	Be	25. Was case refe examiner?			ospital:				0	hac		(Check only			
of	Phys r this ral dir	. To	1 Yes 2	<u> </u>	110	1 13	npatient ol Injury		VOutpatier 3b. Time o	IL 3 DOA	4 🗆 1		ne 5 Res		Other (Special	<u>(v)</u>
ion	ath. or: Afte	ation	1 Natural 2 Accident	5 Pend inves	stigation	(Mo	e ol Injury onth, Day Y	ear)	Injury	Wo	rk?]Yes 2[,	
Divis	after de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Coul dete	d not be mined	28e. Plac build	ce ol Injury ding, etc. (- At home Specify)	e, farm, st	reet, factory, office		2	28I. Location City or To	Street and	d Number or Run	al Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai C	29a. Certifier (Check only one)	Certify 2 Medic	ring Physi at Examin	er: On the	ne best of r basis of ex inner stated	amination	edge, deat n and/or in	h occurred at the t vestigation, in my	ime, date a opinion, de	and place, a eath occurre	and due to the ad at the time	cause(s) , date and	and manner as s place, and due t	stated. o the cause(s)
	within To th compl	Me	29b. Signature an	6.74	-					29c. Licen	se number	r		29d. Date	e signed (Month,	Day, Year)
			Cyv	thua	M	nau	1)			DOO	513	47		9	128/05	
	10x1		30. Name and add	a Sor	ian	0 6	701			Print)	t. B	ustiv	nore	MS	21204	1
	Sta Regist		31. Date filed (Mo	P 3		32.	Registrar's	Signatur	6001							

				partment of Health and Mental I	Hygiene 21726
			1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No. 005 31726
	Physicia /Medic		Valentine Edward		ember 29,2005 5:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Manor Care Woodbridge Valley 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Catonsville y) If Under 1 Year If Under 24 Hrs. 8. Date of	Baltimore (Birth 9 Birthplace (State or Foreign
Ŀ	Funeral Director		192–12–4091 1 XM 2□F 80 Yrs.	Months Dave Hours Min (Month	of Birth n, Day, 1 11,1925 9. Birthplace (State or Foreign Country) PA.
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Itams 23e or 28e-f show int, The Medical Examinar must be notified at	ĮŎ	MD. Howard Ellico	H C.t.	1 ☐ Yes 2 Mo
	r 28e	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with 23e o	al D	4520 TULIPWAY	21043	USA
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 Never Married 2 Married 1 Married 1 Married 2 No If Yes, Give 3 Midowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🛣 No Specify:	Specify: White
9	2 hou	ted		edent's Usual Occupation re kind of work done during most of working	16b. Kind of Business/Industry
215	thin 7 e. an "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)	61 /
7	led wilygien her th	Cor		eelworker	Steel
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "netural", or Itams 23e or 28e-f show any injury or other traumatic avant, Ita Medical Ezanti or must be notified at once.) Be	17. Father's Name (First, Middle, Last) 205@Dh Krzysko	18. Mother's Name (First, Mid Stella W	
37	should be find Mental 8 marked or	To		iling Address (Street and Number or Rural Route Nu	
	and 2 valth a 27 is		MARK E. KNYSKO (SON) 456	20 Tulipway Ell.	· cott city md 21043
Baltimore,	of He		1 M Burial 2 Cremation 3 Removal from State	position (Name of Date ematory or other place)	20c. Location - City or Town, State
<u>Ē</u>	Pages tment of I tant: if Its jury or o	17	'4 □ Donation 5 □ Other (Specify) Gardens	of faith 10-1-05	BALTO. MO.
Baj	permit. Page Department Important: fl any injury o			22. Name and Address of Facility LONDELLY FUNERAL Home	Oundalk Stero . 20222
			23a, Part1, Enter the disease or complications that caused the death Do not e		orv arrest. Approximate
	Physician	5 11	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	I value acide	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	r values quesce	Christian
	Examiner		5 x uentially list conditions b.		
7	rted	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
ſ Ć	execu in and ial-tra	Examin	that initiated events c. Due to (or as a consequence of):		
8760,	icate be executed physician and s the burial-transit	cal	d		
9	death certifica attending ph d for use as the	Med	IF FEMALE:		
Вох	attenc for us	cian/	A Dreamant at time of death 5	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
o.	at the death certi	Physician/Med	1 Yes 2 No 9 Unknown		
S, D	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. [Did tobacco use contribute to the cause of death?
ord	w requires tha s been signed I should be det	ted	(typenten) con		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Vital Record	e law has b	Completed	(Jrubell)	a	Was an 24b. Were autopsy findings available prior to completion of cause of death?
a F		e Col		1 □ Ye	es 2 No 1 Yes 2 No
	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check of	Residence 6 Other (Specify)
6 ر	는 는 E		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Descr	ribe how injury occurred
Sior	Attanding r death. actor: After by the funer	catic	1 Natural 5 Pending (Month, Day 1ear) Injury 2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	
Division of	f or Attanding latter death. Diractor: After I in by the funer	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)
_	To the Hospital or Attane within 24 hours after death To tha Funeral Diractor: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	n 24 h n 24 h ha Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the ti	ime, date and place, and due to the cause(s)
	To the within 2 To tha I	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	/			1727369	7170103
	5		30. Name and address of person who completed cause of death (Item 23a) (Type		Rd 21208
٠,	Sta	ite	31. Date liled (Month, Day, Year) 32. Registrar's Signature	- A	,
	Regist	ar	SEP 3 0 2005 Augus 15 A	jeww	

			1 - State Registrar	ate of Ma	ryland / [-	tment of H <i>ificate of L</i>	ealth and M Death		giene O	05	31727
	Physici		1. Decedent's Name (First, Middle, Last) ISIDORE	ŀ	KRICHIN	SKY			2. Date of Dea	Day	Year L6, 200	3. Time of Death
•	/Medic Examir	2	4a. Facility Name (If not institution, give street Sinai Hospital of	0 11	imor		4b. City, Town, or South	Location of Death	City		nty of Deati	N/A
7	Funeral Director		5. Social Security Number 6. Sex 1212-07-6245 121 M 2	7. Age	(In yrs. last bir	rthday)_ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt Month Day 10/20/		9. Birth Con	nplace (State or Foreign untry) N.Y.
34	ehow	70	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
2,2	ith tha Ma or 28a-f	Director	MD BALTIMORE 10e. Street and Number		BAL	_TIM(10f. Zip Code			10g. Citizen	of What Co	
Krichinsky	Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. do other then "natural", or items 23a or 28s-f show event, the Madical Examiner must be natified at	Funeral (Ar	as Decedent E med Forces?		13. W	21208 as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp. n, Mexican, Puerto		U.S.A.	Race - Ame Black, White	rican Indian, e, etc.
	5-0036 72 hours aftunation insturation i	by	3 ☐ Widowed 4 ☐ Divorced Ye	Yes, Give ear or Dates:			Yes 2 No	Specify:		Spe		ITE
dore	vithin 72 and.	Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12)	pleted) ollege (1-4or 5-	-)	(Give k	ind of work done of ONOT use retired,	furing most of work	ing			APPLIANCES
2	Iryland 2 should ba filad of Mantal Hygi marked other imatic event, 1	Be	17. Father's Name (First, Middle, Last) HYMAN		KRICH			18. Mother's Name	e (First, Middle,		ame)	VETSKY
DA	Maryla d 2 should I th and Mani ? Is market	7	19a. Informant's Name/Relationship (Type, Pr		195	b. Mailing	Address (Street a	APT 1 -			wn, State, Z	(ip Code)
3	or Haal		VIOLET KRICHINSKY / 20a. Method of Disposition 1 2 Burial 2 Cremation 3 Remov	WIFE al from State	20b. Place o cemete	of Dispos ary, crem	tion (Name of atory or other place	θ)	Date	20c. Locatio	on - City or	Town, State
of Known	Baltimore, parmit. Pagas 1 s Dapartment of Ha Important: If item eny injury or othe once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Second Lisch ee		FORBAN	22.		s of Facility SOL		ON & B	ROS.,	INC.
\$ B	Physician /Medical Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Rep V Due to (or as a	a consequence	of):		ERSTOWN R g, such as cardiac LWE Curebes	the street of the second state of the second s		LLE,	Approximate Interval Between Onset and Death
	BOX 6 death cartiff a attending id for use as	Physician/Medical	in the past 12 months?	yes, outcome d □Live birth □Pregnant at □Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				Date of deli Month	ivery Day Year
	ecords, P.O law requires that the as been signed by th	by	Part II. Other significant conditions contribut	ing to death bu	it not resulting i	in the un		en in Part I.			/	the cause of death?
	Il Record Tha law require tate has been si page 2 should I	Completed	- Macrocolor	1010		1	over cere		24a. Was autop perfo			stopsy findings available completion of cause of
	of Vital F Physicien: Th r this cartificate ral director, pag	o Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al: 1 Appatien	nt 2 ER/O	utnationt	3 DOA Othe	26. Place of Deat		one)		
	Division of Vital Records, to the Hospital or Attending Physicien: The law requires t within 24 hours after death. To the Funaral Director: Atter this cartificate has been signe applietaly filled in by the funaral director, page 2 should be	Certification: To	27. Manuer of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28	a. Date of Injur (Month, Day e. Place of Inju	y Year) 28b.	Time of Injury	28c. Injun Work		28d. Describe I	how injury oc	curred	ural Route Number,
	Div Hospital or / 4 hours after Funaral Dire Bly fillad in b	edical Certl	29a. Certifier (Check only 2 Medical Examiner: C	On the basis of	of my knowledg	ge, death	occurred at the tin	ne, date and place, pinion, death occur	City or Toward and due to the red at the time,	cause(s) and	manner as	stated. to the cause(s)
	To the P within 24 To the F complete	Med	29b. Signature and title of certifier	ind manner sta	ted.		29c. License	e number		29d. Date sig	gned (Monti	h, Day, Year)
	St	p ate	30. Name and address of person who comple THOMAS GENUS 31. Date filed (Month, Day, Year)	ted cause of de	eath (Item 23a)	(Type, F	Print) SPITAL	BALTI	MORD	MD	212	15

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 05 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Kratochvi Michae Pau September 00:01 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Bayview Hospita If Under 1 Year If Under 24 Hrs.
Months Days House Johns Hopkins 8. Date of Birth (Month, Day, July 20 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Country) Maryland 1√2 M 2□ F 218-48-2732 58 Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mast ke notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Dunda1k 10e. Street and Number 10g Citizen of What Country? 10f. Zip Code 21222 U.S.A. 7805 West Collingham Drive Apt. B. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 Florist Flower Shop NA 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Kratochvil Angeline Buzgirerski 2 Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1332 Stevens Ave. Arbutus, Maryland Apt. 1 2
of Disposition (Name of Date 20c. Location - City or Town, State Michael Kratochvil (Son)
20a. Method of Disposition Apt. 1 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If Ite any injury or ot snce. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) October 1, Bayview Crematory Inc 2005 Baltimore, Maryland 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A.
Raltimore, Maryland 21224 21. Signature of Foheral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Heratic **Physician** Lears resulting in death) /Medical Due to (or as a consequence of) Examiner Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed disease Stage attending physician and I for use as the burial-tran: Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Munknown should b Alcoholi 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) axaminer? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Thpatient dir 2 ER/Outpatient 3□ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number Nadeen Hosein, Medical Kes -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 4500 Eastern Nadeen Hosein Johns Hopkins Bayview Hospital, Avenue 31. Date filed (Month, Day, Year) SEP 3 0 2005 32 Registrar's Signature State

Registra

Coside

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Blanche Month **Physician** 50 PM 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Ago (In yrs. last birthbay) QQ Yrs. Side Morning Silversity Number Park Ville
If Under 1 Year If Under 24 Hrs. Assisted Living Date of Birth (Month, Day, 2 - 27. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 200 F Director MISSOUR Usual Residence of Deceder 10b. County 10a State 10d. Inside City Limits 10c. City, Town or Location traumatic event, the Mudical Exercical rount be notified at Glen 1 Yes 2 No Completed by Funeral Director SALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 or Iteme 23s 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 KNo Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify onfy highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
hife. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: If Itam 27 is marked other than "! al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be DearR awrence 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Dispolition (Name of cometery, crematory or other place) 2105 rultorc 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 5 3 Removal from State Department of Important: If eny injury or one Valley Man. Goral 4 □ Donation 5 □ Other (Specify) 7 imonium 21. Signature of Funeral Service Liversee 22. Nam and Address of Facility BALTI MORE, MO Z (234). 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated the disease of the disease o Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician trickstug /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performed? Yes 2 1 Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assidthum Hospital: 1 ☐ Yes 2 X No 2 ER/Outpatient 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 31 Date filed (Month, Dav.

なと といいと

Horrital Bot Building

30. Na se a d address of person who completed carse of death (Item 23a) (Type, Print) Good

2005

0

32. Begistrar's Signature

		1. Decedent's Name (First, Middle	e, Last)						Death		2. Date of I			Vac-	3. Time of De	ath
icia dici	al	Wilda J. Lepl											28,	^{Үөаг} 2005	2:35	A M
ine	er	4a. Facility Name (If not institution Stella Maris	n, give st	reet and nu	ım ber)			, Town, or Ioniur	Location on	of Death		4	tc.County of Balti		2	
		5. Social Security Number 212–32–3859	6. Sex	M 2 ⊠ F	7. Age (In yr. 88	s. last birthday, Yrs.) If Unde Months	Days	Il Under Hours	24 Hrs. Min.	8. Date of the (Month), March	Birth Day, Yea 22,	1917	9. Birthi Coul Mar	otace (State or F	oreign
	}	Usual Residence of Decedent 10a. State 10b. County			10c. (City, Town or L	ocation.				1				10d. Inside City	Limits
	Funeral Director	MD n/a	-		В	altimor									1 ∰Yes 2	□No
	ă	10e. Street and Number						p Code					Citizen of Wh		,	
	erai	1319 Light St.	12	2. Was Dec	edent Ever in	U.S. 13.		230	spanic Ori	gin? (Sp	ecity Yes or i		ted St			
	by Fun	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	ned	Armed Find Test of Tes	orces? 2∰No ive		If Yes, spe		n, Mexican Specify:	i, Puèrto	ecify Yes or (Rican, etc.)			, White,		
	ted	15. Deceden	it's Educa	ation		16a. Dece	edent's Usu	al Occupa	tion			16b.	Kind of Busi	iness/in	dustry	
	Completed	(Specify only higher Elementary/Secondary (0-12)	si grade		(1-4or 5+)	life.	e kind of wo DO NOT u	urk doné d ise retired	uring mosi)	or worki	iiig					
		12			<u> </u>	Cler	ical_			,			ledica:			
ı	Be	17. Father's Name (First, Middle,	Last)										en Sumame))		
	ို	Harry Lynch	hin /Ti-	a Print!		10h 14. **	line Add	n /6*===			ce Shr		. a. 7	tat	Code	
		19a. Informant's Name/Relations			tor								or Town, St			
		Jonelle Johnson 20a. Method of Disposition	11 /	uaugn		Place of Dispe	osition /Na	me of			1Cum,		land 2 Location - C			
		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		moval from	State	cemetery, cre Bayview	matory or	other place		g / 20	/2005				iaryland	
		21. Signature of Funeral Service		· 1											f Lensd	
		> 1001 De	X	UN	771	2	710 II	ammar	nde F	OREST	Rd I a	nedo	wne, N	MD 2	1227	OWLL
		23a. Part1. Enter the disease, or shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death).	complication only one	e cause on	each line.		nter the mod	de ol dying							Approximate Interval Betwe Onset and Dea	ən ith
	dicai	shock, or heart lailure. List Immediate Cause (Final	a. b. c. d.	End Due to	each line.	ath. Do not en Renal D: equence of):	nter the mod	de ol dying							Approximate Interval Betwe	en aith
	nysiclan/Medicai Examiner	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to amendiate cause. Enter Underlying Cause (Disease or injury that initiated events	a. b. c. d.	End Due to Due to Due to	each line. Stage R (or as a conse	ath. Do not en Renal D: equence of): equence of): equence of): anancy tal death 3[nter the mod	e eregnancy					23d. Date Month	of delive	Approximate Interval Betwe Onset and Dea	ath
	by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any least of the cause of the cau	a. b. c. d.	Due to Due to Due to	Stage R (or as a consection of pregion at a time of power)	ath. Do not en Renal D: equence of): equence of): equence of): equence of): equence of):	iseas iseas	e oregnancy pecify)	j, such as	cardiac	23e. Die	d tobacco	23d. Date Month	of delive	Approximate Interval Betwee Onset and Detection of the Interval Betw	ar th?
	by Physician/Medicai	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. b. c. d.	Due to Due to Due to	Stage R (or as a consection of pregion at a time of power)	ath. Do not en Renal D: equence of): equence of): equence of): equence of): equence of):	iseas iseas	e oregnancy pecify)	j, such as	cardiac	23e. Die	d tobacco	23d. Date Month	of delive	Approximate Interval Betwee Onset and Dec	ar th?
	Physician/Medicai	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. b. c. d.	Due to Due to Due to	Stage R (or as a consection of pregion at a time of power)	ath. Do not en Renal D: equence of): equence of): equence of): equence of): equence of):	iseas iseas	e oregnancy pecify)	j, such as	cardiac	23e. Die 1[24a. Wi	d tobacco	23d. Date Month Duse contrib 2 \(\text{No} \) 3	of deliver	Approximate Interval Betwee Onset and Detection of the Interval Betw	ar th?
	Be Completed by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, It are a support of the support	a. b. c. d. 23	Due to Due to Due to Due to	each line. Stage R (or as a consection of pregion of	ath. Do not en Renal D: equence of): equence of): equence of): nancy nal death 3[death 5[equence of the companion of t	iseas Ectopic p Other (s)	e regnancy pecify) cause give	g, such as on in Part I. 26. Ptace	cardiac of	23e. Did 1[24a. With au per 1 Yes an Check on)	d tobacco	23d. Date Month D use contrib 2 \(\text{No} \) 3 24b. We price of the price of	of deliver	Approximate Interval Betwee Onset and Deadler on Page 19 Page	ar th? known
	To Be Completed by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Ill any leading the sequentially list conditions. Ill any leading the sequential list conditions. Ill any leading the sequential list conditions are sufficient to the sequential list condition. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Unknown Part II. Other significant conditions. If yes 2 No No No No No No No	b. c. d. 233	Due to Due to Due to Due to Due to	seach line. Stage R (or as a consection of pregonant at time of nown death but not recommend to the consection of the	ath. Do not en Renal D: equence of): equence of): equence of): equence of): equence of):	iseas Ectopic p Other (s)	e oregnancy pecify) cause give	g, such as an in Part I. 26. Ptace 17. 4 □ Nu	of Death	23e. Dic 1[24a. Wings 1 Yes 1 Check on	d tobacco	23d. Date Month D use contrib 2 \(\text{No} \) 3 24b. We price of the price of	of deliver	Approximate Interval Betwee Onset and Deadler on Deadle	ar th? known
	To Be Completed by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any least of cause, Enter Underlying Cause, Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions. If the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	a. b. c. d. 23 ons cont.	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. Stage R (or as a consection of pregion of	ath. Do not en Renal D: equence of): equen	iseas	e oregnancy pecify) cause give	g, such as in Part I.	of Death	23e. Did 1[24a. Wh au pe 1 Yes 1 Check on me 5 Re 28d. Describ	d tobacco	23d. Date Month o use contrib 2 \(\text{No} \) 3 24b. We produce decorate of the produce of t	of deliver	Approximate Interval Betwee Onset and Deadler on Page 19 Page	ath th? known ailable se ol
	al Certification; To Be Completed by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any least any least and list cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown Part II. Other significant conditions are summer? 1 Yes 2 No 27. Manner of Death 1 Rotural S Pendir investi Pendire	a. b. c. d. 23 ons cont. I Ho	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. Stage R (or as a consection of pregion of	ath. Do not en Renal D: equence of): equen	iseas Ectopic p Other (s) underlying of M Utreet, lactor	e oregnancy pecify) cause give OA Other 28c. Injury Work 1 Yes	g, such as 26. Ptace 27. 4 □ Nu 28. 2 □ 1	of Death	23e. Did 1[24a. Wi au au au Check on me 5 Re 28d. Describ 28l. Location City or 1	d tobacco	23d. Date of Month Do use contrib 2 \(\text{No} \) 3 24b. We prive determine the private determine the prive determine the prive determine the	of deliver h Dute to the series autor to coor to coor ath? Yes (Specified of the series are series as series as series are series as series are series as series are series as series are series as series are series as series are series as series are s	Approximate Interval Betwee Onset and Determin	ath th? known ailable se ol
	Certification; To Be Completed by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any least of cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the condition of the c	a. b. c. d. 23 ons cont. Hong gation not be nined Examinate	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. Stage R (or as a consection of pregion of	ath. Do not en Renal D: equence of): equen	Ectopic p	e oregnancy pecify) cause give OA Other 28c. Injury Work 1 Yes	g, such as 26. Ptace or: 4 □ Nu at ? es 2 □ t	of Death	23e. Did 1[24a. Wi au au au Check on me 5 Re 28d. Describ 28l. Location City or 1	d tobacco	23d. Date of Month Do use contrib 2 \(\text{No} \) 3 24b. We prive determine the private determine the prive determine the prive determine the	of deliver h Dute to the series autoporto color to color	Approximate Interval Betwee Onset and Determine Conset th th? known ailable se of	
	edical Certification; To Be Completed by Physician/Medical	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any leading Immediate Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the	a. b. c. d. 23 ons cont. Hong gation not be nined Examinate	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. Stage R (or as a consection of pregion of	ath. Do not en Renal D: equence of): equen	Ectopic p Other (s) underlying of M treet, lactor	e oregnancy pecify) cause give oA Other work 1 \(\) ry, office d at the time n, in my op c. License	g, such as 26. Ptace or: 4 □ Nu at ? es 2 □ t	of Death rsing Hoo No	23e. Did 1[24a. Wi au au au Check on me 5 Re 28d. Describ 28l. Location City or 1	d tobacco	23d. Date Month o use contrib 2 No 3 24b. We prive det 1 Control 6 MOther lury occurred and Number and Number and place, and manning place, and manning place, and manning place.	of deliver h Dute to the series autoporto color to color	Approximate Interval Betwee Onset and Determine Conset th th? known ailable se of	

SEPTEMBER 28, 2005

WILDA LEPLEY

05-06472 Paul McCraw

Amend item#12.perFH.G847.9/30705 III

			Americ 1 Leng 12, p	State of Maryland			Mental Hygi	ene nos	21721
			Hegistrar		Certifica	te of Death		g. No.	31/31
	Physicia		1. Decedent's Name (First, Middle, Last,	h			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Death	Septembe	r 22, 2005	05:48 A ^M
	Examin	ÇΙ	Johns Hopkins Bayv			Baltimore		1//1	-
	Funeral		5. Social Security Number 6. Se		ast birthday) If Unde	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Pay,	Year) 9 Birth	place (State or Foreign
	Director	4	Usual Residence of Decedent	49	Yrs.		March 3	1956 110	aryland
	yland		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Ba-f el	ctor	Maryland N/	4 E	saltim	ore			1 Yes 2 No
	with the	Dire	10e. Street and Number		10f. Z	ip Code クノクのク	10	g. Citizen of What Cou	intry?
	death ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was Dece	edent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer	
9	or ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 Xes 2 No Un	k 1 Yes	ecify Cuban, Mexican, Puerto 2 🕱 No Specify:	Hican, etc.)	Black, White	, etc.
Ş	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow hadical Examinar roust be notified at	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a. Decedent's Us		1	6b. Kind of Business/li	acr_
715	in 72 In "na Medic	plet	(Specify only highest grad	College (1-4or 5+)	(Give kind of w	ork done during most of wor	king	OD. ()	0 C C+
21	filed with Hygiene other the	Com	12	2	Custe	odian		Post (Ittice
Maryland 21215-0036	ntal H od oth	To Be	17. Father's Name (First, Middle, Last)	1000011		18. Mother's Nam	ne (First, Middle, M	aiden Sumame)	21/05
Z Z	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Depardment of Heelth and Mental Hygiens. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show moortant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macilcal Examinant counties at any injury or other traumatic event, the Macilcal Examinant counties at any injury or other traumatic event, the Macilcal Examinant Counties at any injury or other traumatic event, the Macilcal Examinant Counties are any injury or other traumatic event, the Macilcal Examinant Counties are also as a constant of the Counties of t	٢	19a. Informant's Name/Relationship (T)	VPO, Print) (Wife)	19b. Mailing Addres	ss (Street and Number or Ru	ral Route Number,	City or Town, State, Z	ip Cbde)
-	and 2 sellth a 27 is er trau		Mrs. Desiree	S.McCraw	9221	1 Central	Ave. I	Balto.N	11.21202
Baltimore	of He if item or oth		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ I		lace of Disposition (Na emetery, crematory or	other place)	Date 2	Oc. Location - City or T	own, State
Ħ.	it. Pages dment of rtant: if ii njury or c		4 Donation 5 Other (Specify, 21. Signature of Funeral Service/Licens	160	eenMount	Crematory 1013	5/2005	Scelton	Ma.
Ba	permit. Departm Importa		by look	L. Russ	Joseph	n LiRuss F	yneral	tome, P.A.	71216
			23a. Part1. Enter the disease, or comp shock or heart failure. List only of	lications that caused the death	h. Do not enter the mo	ode of dying, such as cardiac	or respiratory arre	st.	Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition	. Hypeter so	in Atha	oschoti	Cerdir	nul Die	Onset and Death
	/Medical Examiner		resulting in death)	Date to (or as a consequent	uence of);	_			
		Jer	if any, leading to immediate	b. Due to (or as a conseq	uence of):				
$\sqrt{}$	and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c					
60,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):				
09289	ate hys	Physician/Medical	•	d					•
Box (death certifica attending pt d for use as t	M/u	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		oregnancy		23d. Date of deli	,
O. B	The law requires that the death certific the has been signed by the attending poses 2 should be detached for use as	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d				Month	Day Year
Φ.	s that the de ned by the a detached		Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
of Vital Records,	aquires en sign	ed by					1 □ Ye	s 2□No 3□Pro	obably 4 Unknown
900	e law requir has been si je 2 should	piet					24a. Was an	24b. Were au	topsy findings available ompletion of cause of
Ä		Completed					perform	ied? death?	2 □ No
Vita	Physician: 'this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Other	ath (Check only one		
	y Phys ar this eral di	7. 10	1 √Yes 2 No 27. Manner of Death	1 ☐ Inpatient 22 28a. Date of Injury (Month, Day Year)	R/Outpatient 3□ D 28b. Time of	28c. Injury at Work?	ome 5 Reside	nce 6 Other (Spec	ufy)
ion	Attending I ir death. ector: After by the funer	atio	1 grNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division	i or Attenation after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury · At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	To the Hospitei or At within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my kno	owledge, death occurre	d at the time, date and place	and due to the ca	use(s) and manner as	stated.
	To the Hospitei within 24 hours a To the Funeral I completely filled	Medical		niner: On the basis of examina and manner stated.	tion and/or investigation	on, in my opinion, death occu	rred at the time, da	ite and place, and due	to the cause(s)
	To the To the complet	Ž	29b. Signature and title of certifier	1-11	2	9c. License number	İ	d. Date signed (Monti	
	1		Throdored	1. Kirgan	10	O.C.M.E.		eptember 2	
	5		30. Name and address of person who of the UDURE LIE	completed cause of death (Iter	n 23a) (Type, Print) 111 Penr	Street, Bal	timore, M	aryland 21	201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature Anash	60			
1	Regist	rar	OLI 0 0	CEDUS AND STATES	Jon John St.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend/Unpend item/24a, 23a, 27, 28a-f, perMF, C849, 11-16-05 TT

State of Markiand/Department of Health and Mental Hygiene

			1 - State Amend Registrer Amer			ie G847	1/2-139 Cei	tificate of	Death9-			200	5 (31732
1	Physic		Decedent's Name (Fill LAURA ANN		•					2. Date of Month Septer	Death nher	^{Day} 28 2	ear	3. Time of Death 5:42A M
	/Medi Examii		4a. Facility Name (If not			ber)		4b. City, Town,	or Location of D			4c. County of		J:42A
		ш	University					Baltimo]	BALTIMO		
256	Funeral Director		5. Social Security Number 078-66-403 Usual Residence of Dec	1 1	9X □M 2ĂF	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Month, NOV .	Birth Day, Yea 24,	1971 N	Birthpla Countr EW Y	ace (State or Foreign ORK
	/land			. County		10c. City	y, Town or Lo	cation					10	d. Inside City Limits
	a-fsh	ctor	NEW YORK C	HAUTAUQ	UA	LAK	EWOOD							1 ☐ Yes 2 💆 No
	or 28	Dire	10e. Street and Number					10f. Zip Code			10g. (Citizen of Wha	at Countr	y?
	s 23a	rai	119 CHAUTA	UQUA, A				14750				NITED S		
21215-0036	s 1 and 2 should be filed within 72 hours atter death with the Maryland if Health and Mental Hygiene. It marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Examinat must be notified at	by Funeral Directo	11. Marital Status 1 ☒ Never Married 3 ☐ Widowed 4 ☐		12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No	1	Was Decedent of Yes, specify Cub		? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Black, Specify:	America White, et	tc.
5-0	72 h	etec	15. (Specify or	Decedent's Ed	ucation de completed)		16a. Deced (Give	lent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b.	Kind of Busin	iess/indu	istry
121	within ene.	Completed	Elementary/Secondary	(0-12)	College (1-	4or 5+)		OO NOT use retire CLERK	ed)	y	, n	RETAIL		
	filed Hygid othar ant, II	e Co	17. Father's Name (First	Middle, Last)	<u>-</u>		DALLO	CLERK	18. Mother's	Name (First, Mida				
ılan	ould be filed with Mental Hygiene. arked othar thar atic avant, Ire M	To Be	JOHN W. MI	LLER						IA ANN MA		,		
Maryland	2 should and Men la marke	ľ	19a. Informant's Name/I							r Rural Route Nun				
	l and fealth im 27 har tr		JOHN W. MII		FATHER	OOL D		UTH ST.,	P.O. B	309,				
Baltimore,	t. Page rtment o rtant: If		20a. Method of Disposition 1 ☐ Burial 2 ★ Cre 4 ☐ Donation 5 ☐ 21. Sign ture Funeral	emation 3 Other (Specify)	tate Cé	emetery, cren 'RO CRE	MATORY,	INC. SE	PT. 29,	CA	Location - Cit	LLE.	MARYLAND
ä	Depar Impo any ir		King	NI			K 4	IRKLEY÷R 21 CRAIN	UDDICK HWY	FUNERAL S.E., GL	HOME EN B	P.A.	MD	21061
68760,	/Medical Examiner as the burial-transit	Medicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition from the condition of any, leading to immediate. Entail Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (o b	r as a consequ	ence of):	d injuri	es with	complica	atio	ns	Ö	Approximate nterval Between Onset and Death
P.O. Box 68	t the death ce by the attendii ached for use	Physician/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	FICTEIL		th 2 ☐ Fetal nt at time of de	death 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of Month		ay Year
	res tha igned be det	by P	Part II. Other significant	conditions co	entributing to dea	th but not resu	lting in the un	derlying cause giv	ven in Part I.	23e. Dio	tobacco	use contribu	te to the	cause of death?
ord	w requir been si should	eted								- 10	Yes :	2□No 3□] Probab	oly 4 Unknown
al Records,		Completed	05 W							24a. Wa aut per 1 \square Yes	onsv	prior	r to comp	y findings available iletion of cause of
Vital	Phyaician: this certific ral director,	o Be	25. Was case referred to examiner? 1 X Yes 2 No	-	Hospital: 1XXnp	nationt 2 🗆	ER/Outpatient	3[] DOA Ott		Death (Check only			-	
J of		 	27. Manner of Death			Injury Day Year)		28c. Inju	4 14013111	g Home 5 Res			Specify)	
sior		atio	2 X Accident	Pending investigation	9/23/		7:47 P	M 1	Yes XXNo	Subject	fe1	1 down	sta	irs
Division	F 6 F 5	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of building	Injury - At hor , etc. (Specify,	me, farm, stre	et, factory, office						ill Pond
	pital ours al		20a Cartifica 1	Continue Div	dwell		4 1 4 4			Rd.	Wart	on, MD)	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	ledicai	one)	Wedical Exem	iner: On the bas and manne	is or examinati	vledge, death on and/or inv	estigation, in my c	ppinion, death or	ace, and due to the ccurred at the time	e cause(: e, date ar	s) and manne nd place, and	r as state due to th	e cause(s)
	To To	Σ	29b. Signature and title of	r certifier	1.			29c. Licens				ate signed (M		
7			30 Name and address	au.M.	King	of door ("	02-) (7		C.M.E.		Sej	ptember	29	, 2005
			30. Name and address of	Linga who c	ompieted cause	oi ueath (Item		*	ceet. Ra	altimore,	Мат	·vland	212	201
	Sta Registr		31. Date filed (Month, Da	,	1	jistrar's Signati	nte		200, DC	,	1101	y rand	212	.01
			SEP	3 0 200) Francis	2 /3	1000	4.7						

		1	State State	te of Maryland / Depa	artment of Health and Natificate of Death	Mental Hygie	2005 3	31733
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) Margaret M. 4a. Facility Name (If not institution, give street a	ary Martin	4b. City, Town, or Location of Death	2. Date of Death Month September	Day Year	3. Time of Death 7:45 P M
# " #	Examin Funeral Director	C1 .	Stella Maris Hospic 5. Social Security Number 214-03-4549 6. Sex	7. Age (In yrs. last birthday)	Timonium If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 24, 1	Baltimor	re ace (State or Foreign York
	th the Maryland or 28a-f show a notified at		Usual Residence of Decedent 10a. State 10b. County laryland N/A 10e. Street and Number	10c. City, Town or Lo	Ore 10f. Zip Code	10ç	J. Citizen of What Counti	d. Inside City Limits 1 X Yes 2 □ No
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural; or iteme 23s or 28s-f show supprintury or other treumatic event, I'm Mudical Exercises must be notified at ance.	d by Funeral Directo	1 Never Married 2 Married 1 If Y	Is Decedent Ever in U.S. ned Forces?	21224 Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto			ite
Maryland 21215-0036	filed within 72 h I Hygiene. other then "netu	e Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co 12 17. Father's Name (First, Middle, Last)	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) memaker 18. Mother's Nam	ne (First, Middle, Ma	Own Home Jiden Sumame)	ıstry
, Marylan	and 2 should be ealth and Menta in 27 is marked ser treumatic ev	To Be	19a. Informant's Name/Relationship (Type, Pri Judith Martin Dau	ghter 145	Rose ng Address (Street and Number or Ru East 15th Street,	Apt 8P No	ew York, New	w York
Baltimore,	permit. Pages 1 Department of Hi Important: If Iter eny injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. Signature of Foreital Service Libensee	Hilltop S	ervice Corp. 9-29 2. Name and Address of Facility Rui 1050 York Road	-2005	Funeral Hor	ryland me, Inc. 1204
4	Physician /Medical Examiner Portial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	REAST CANCER Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arres	"	Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e attending phy: ed for use as the	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
Vital Records, P.	w requires been sign should be	Completed by Ph	Part II. Other significant conditions contributi	ng to death but not resulting in the u	underlying cause given in Part I.		24b. Were autop prior to corr death?	ably 4 XIUnknown by findings available apletion of cause of
of	ding Physician: n. Alter this certifica funeral director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Nanner of Death 1 Natural 5 Pending 2 Accident investigation	al: 1 Inpatient 2 EP/Outpatie a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	ith (Check only one,	X No 1 ☐ Yes : ce 6 X Other (Specify	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the fune	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28d 29a. Certifier (Check only) 1 Certifying Physician 2 Madical Examiner: C	Place of Injury - At home, farm, st building, etc. (Specify) : To the best of my knowledge, deal in the basis of examination and/or in different stated.	reet, factory, office th occurred at the time, date and place investigation, in my opinion, death occurred.	City or Town,	use(s) and manner as sta	ated.
	,	Me	29b. Signature and title of certifier 30. Name and address of person who complete	ed cause of death (Item 23a) (Type	29c. License number D43721	29	d. Date signed (Month, L	Day, Year)
	St Regist	ate rar	DR. TARIO MAHMOOD 2 31. Date filed (Month, Day, Year) SEP 3 0 2	CC Desistante Cianatura	EY RD. TIMONIUM,	MD 21093	,	

DHMH 17 Rev 1/2001

Amend item#31, perDVR, G347, 9/30/05 11

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Michalson 1:55 AM BAIRD 09 27 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 1. M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Yrs. 218-26-8424 09/11/1928 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3201 OLD POST DRIVE APT. #1 21208 U.S.A. Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 🛣 No WHITE Specify: ģ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PARTNER UNIFORM COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY **MICHELSON** ္ရ RUTH BRAUNSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 OLD POST DRIVE APT. 1 - BALTIMORE, MD 21208 ROSLYN MICHELSON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/29/2005 WOODLAWN, MD BETH TFILOH CONG. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Scott III with 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End disease or condition resulting in death) Sta Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 🗌 Yes **2**N₀ Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Funeral

Director

show

or then "naturel", or items 23a or 28e-f showing the Medical Examples out the notified at

within 72 hours after death with the Maryland

12 should be filed within 7 h and Mental Hygiene. 7 Ie marked other then "r

Pages 1 and 2 should be nent of Health and Mental

if Health in

permit. Pages 1 Department of H Importent: If ite any injury or ot once.

Baltimore, Maryland 21215-0036

burial-transit attending physician and the as signed by the all d be detached for

certificate be executed Exami completely filled in by the funeral director, Certification: To After

Physician/Medical þ Completed Be

P.O. Box 68760. Records, Division of Vital death. Director: after within 24 hours a To the Funerel L

the

Vd

State Registrar

OUP MOTHE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2005

5 Pending

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date liled (Month, Day, Year)

investigation

6 Could not be determined

32. Aegistrar's Signature

Brahim Elouardighi, Jewish Convalescent Center, Baltimore, MD

1 Yes 2 No

063174

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

Amend item#15, per Print in Flack Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EPTEMBE 27 2005 OMER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner talou ltim a 5. Social Security Number 2/6-52-1996 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1**X**M 2□F Months Hours Yrs. Director maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Copartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at Yes 2 □ No Director 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: a þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)_____ (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) dustual Insulator 44 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nontgomery Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 7 n. Bentalou Bacto, md. J: montgomery 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Kine mem. t 3-05 ark 10-(Candads toun 21. Signature of Figheral Service Licenses 22. Name and Address of Facility
320 Fed Hinton Pass
Gerry P. march runeral Home pallo-nd, 21229 he is sease, or complications that caused the death. Do not enter the mile of dying, such as cardiac or respiratory arrest art failure. List only one cause on each line. 23a. Part . Enter the season show of heart failure. Approximate Interval Between Onset and Death Immediate Cal se (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy be detached for in the past 12 months? Month Year Dav 5 Other (specify) 1 Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) 2 🗆 No Yes Other Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 4 hours after death. 2 Accident investigation 1 Tes 2 🗆 No 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Moges

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

0

mariam

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year) 28/05

		ia.	Please 1 - State Registrar	State of Maryland / Dep		Mental Hygie		31736
	Physici /Medic		1. Decedent's Name (First, Middle, Last Francina Elizab			2. Date of Death Sept. 24	Day 2005 Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	1	4c. County of Deat Prince G	
3	Funeral		Bradford Oaks Nu 5. Social Security Number 6. Se		Clinton If Under 1 Year II Under 24 Hrs.	8. Date of Birth	9 Rint	hplace (State or Foreign
ŗ,	Director		230-76-4143 Usual Residence of Decedent	□M 2\\ F\ 53 Yrs.	Months Days Hours Min.	March 5,	'ear) Co	shington, D
	a-f show	ctor	MD Prince	Georges Upper	ocation Marlboro			10d. Inside City Limits 1 Tyes 2 No
	3a or 28	al Dire	10e. Street and Number 14611 Colonels C	Choice Road	10f. Zip Code 20772	10ç	g. Citizen of What Co United	untry? States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, if a Medical Epartmer must be routiled at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒Divorced	1 TYps 2 TNo	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
2-0	72 ho natur dical	eted	15. Decedent's Edu (Specify only highest grad	ication 16a. Dece le completed) (Give	edent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	rking 16	6b. Kind of Business/	Industry
Maryland 21215-0036	1 within jiene. r then	Be Completed	Elementary/Secondary (0-12)	College (1-40r5+)	Nurse's Assistant		Medica	1
힏	at Hyg	3e C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Ma	viden Sumame)	
ylaı	Menta arked	To	Osborn Bernard	Nichols	Norma		Nichols	·
, Mar	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (T) Terry Le Jaunt Mo		ing Address (Street and Number or Ru 511 Colonels Choic	e Road, U	pper Marl	boro, MD
altimore,	Pages 1 lent of He nt: If Iten ry or oth		20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Hemoval from State	matoni ocothocologal		oc. Location - City or Beltsville	
Balti	permit. Departming of the post		21. Signature of Funeral Service Licens	mo 1358	12. Name and Address of Facility 1. Properties and Cr 2. Silver Spring, M.		ervices 9	33 Gist Ave
,09	Physician /Medical Examiner partial pa	al Examiner	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ilications that caused the death. Do not enne cause on each line. a. Find Stage Rena Due to (or as a consequence of): b. Atheroslerosis Due to (or as a consequence of): c. Due to (or as a consequence of):	nter the mode of dying, such as cardial	c or respiratory arres	t,	Approximate Interval Between Onset and Death Years
P.O. Box 687	The law requires that the death certificate the has been signed by the attending physogge 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
ds, P	ires that signed b d be deta	b	Part II. Other significant conditions co	entributing to death but not resulting in the t	underlying cause given in Part I.		cco use contribute to	o the cause of death?
Vital Records,	e law require has been sig ge 2 should b	Completed				24a. Was an autopsy	24b. Were au	itopsy findings available
Ě	The ate ha	E OC				performe	ed? death?	2□ No
/ita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hamitali		ath (Check only one)		
of	Physic this o	.T	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		lome 5 Residen	ce 6 Other (Spec	cify)
Division	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, larm, st building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No		et and Number or Ru	ıral Route Number,
Ľ	A Hospital 24 hours a Funeral (edical Ce	29a. Certifier 1 Cartifying Phy (Check only 2 Madical Exam	vsician: To the best of my knowledge, dea inar: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	a, and due to the cau arred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certification		29c. License number	290	d. Date signed (Monta	h, Day, Year)
			1		D19481		Sept. 29	, 2005
			Frank Ryan 1	ompleted cause of death (Item 23a) (Type 4782 Livingston Roa		, MD		
	St Regist	ate	31. Date liled (Month, Day, Year)	32. Resident 's Signature	Locale is			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistraMEND ITEM #10e PER FH G847 9/3/1/10919-6 Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Eunice Prenger SEPTEMBER 29,2005 1:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 219-16-3769 81 Director 20,1924 Baltimore MD. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avant, the Medical Examinat must be notified at 1 ☐ Yes 2 📆 No Directo Maryland Baltimore County Lutherville 12261 10f. Zip Code 10g, Citizen of What Country? 🛱 Roundwood Road 21093 United States death 1 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Itam 27 is marked other then "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Legal Secretary Law Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Vincent Prenger, Sr. Eunice Rowena Collier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2030 Pot Spring Road Mr.James V. Prenger (Brother) Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö Oct.01,2005 permit. Page Department of Important: If any injury or once. Evans Funeral Chapel Forest Hill Maryland 4 ☐ Donation 5 ☐ Other (Specify) L.Gair, Sp2 Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Jelliey 23a. Part) Einer he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical asi attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART FAILURE Y s 2 No 3 Probably 4 Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an RENAL FAILURE page 2 s certificate has autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 After this funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No death. investigation 2 Accident after death Director: / 3 ☐ Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner us stated at the time. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2 To the

State Registrar

0

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

SUSAN MELTZER

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

M.D.

SEP 3 0 2005

ORIGINAL

29c. License number

D 0042410

7601 OSLER DRIVE TOWSON MARYLAND 21204

29d. Date signed (Month, Day, Year)

			For State	State of	Marylar		artment of I		Mental Hyg	giene .g. 2 .005	31738
			Registrar 1. Decedent's Name (First, Middle, La:	st)			inioato or	Douti	2. Date of Dear		3. Time of Death
	Physici		GERTRUDE	М.		PUSE	7		Month Septemb	er 23, 200	
	/Medic Examin		4a. Facility Name (If not institution, giv					or Location of Dea		4c. County of Dea	
	LAdimii	CI	Edward W. McCread			spital	C	risfield		Some	rset
	Funeral		5. Social Security Number 6. S	ex 7		last birthday)		If Under 24 Hrs			rthplace (State or Foreign ountry)
	Director		252 – 32 – 7520	□M 2 🛣 F		78 Yrs.	Months Days	Hours Min	August .	16 ๊ 1927 พั	ashington, DC
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10a Ci	ty, Town or L	anti-n				10d. Inside City Limits
	aryla shov	2	,		100. 01	ty, rown or L					1 ☐ Yes 2 XNo
	№ М 286-1	Director	Maryland Son	nerset				risfield		0g. Citizen of What C	
	with t		3249 Lawsonia Roa				10f. Zip Code	21817	'		
	ns 23	Funeral	11. Marital Status	12. Was Deced	ent Ever in U	I.S. 13	Was Decedent of I		Specify Yes or No-		USA erican Indian
	ter d	I.	1 Never Married 2 Married	Armed Ford	es?				Specify Yes or No- to Rican, etc.)		te, etc.
336	al', or	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland bytylene. do ther then "natural", or items 23a or 28e-f show do ther then "natural", or items 23a or 28e-f show event, the Medical Examinar must be inclined at	Completed	15. Decedent's E			16a. Dece	dent's Usual Occu	pation	andrin a	16b. Kind of Business	s/Industry
218	within 7 ene. then "r	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	kind of work done DO NOT use retire	dd)	nking		
21	filed withi Hygiene. other then	Con	12				Wai	tress			aurant
pu	al Hy d oth	Be (17. Father's Name (First, Middle, Last,)				18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
yla	2 should be and Mental and Mental and Is marked o	2	Edward T. Sterlin						ia Lee St		
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (r, City or Town, State,	
45	ss 1 and 2 should b of Health and Ment item 27 Is marked r other treumetic e	1 3	Donna Wootten (Da	ugnter)	20h I					oury, Mary	
Ore	ges 1 t of F If ite or ot	1 3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from S	ate	-	osition (Name of matory or other pla	1		20c. Location - City or	
Baltimore,	t. Pa tmen tant: tant:	١,	' 4 ☐ Donation 5 ☐ Other (Specif	12 11	Sunr	TO THE OWNER OF THE OWNER OWNER OF THE OWNER OWN	Memorial Pa		. 27, 2005	Crisfield,	Maryland
Bal	permit. Pages 1 Department of H Important: If ite any injury or otl once.		21. Signature of Funeral Service Lice	Blacket	1 Kin	tt	2. Name and Addr Bradsha	w & Sons	Funeral	Home	
			Mary Beth Brag 23a. Part1. Enter the disease, or com	dshaw-Pr	uitt	th. Do not en					ryland 21817
П		Œ	shock, or heart failure. List only	one cause on ea	ch line.	50 1101 011	i .	7.		551,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Care	Dron	is cu	lar	& sea	se		
	Examiner		- 1	Due to (o	ras a consec	quence of):					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (o	r as a consec	quence of):					
Ф	urad ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć	exec an an		resulting in death) Last	Due to (o	r as a consec	quence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	(d							
9	rtifica ng ph as th	Ved	IF FEMALE:							- 1	
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live bir	ome of pregnath 2 Feta	ancy al death 3[☐Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
	e dea the at	Physiclan/Me	1 Yes 2 No	4∏Pregna 9∏Unknov	nt at time of o	death 5[Other (specify)			Month	Day : Bai
P.0	that the de ed by the detached	Phy	Part II. Other significant conditions	antributing to do	th but not ros	sulting in the c	andarhina agusa ai	von in Bort I	23e Did tol	bacco use contribute to	o the cause of death?
Ś,	ires tha signed t be de	b	Fait II. Other significant conditions (contributing to dea	illi Dat Hot 168	sulang in the t	indenying cause gi	VOITIII FAILT.		es 2 No 3 P	
Records,	w require been sig should b	Completed									
360	has has by	ld m							24a. Was a autops perforr	y prior to	utopsy findings available completion of cause of
									1 ☐ Yes 2	2 No 1 ☐ Yes	5 2□ No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			Ottoo Ot	hor:	ath (Check only on		
of	ding Phys h. After this funeral di	-	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	patient 2	ER/Outpatie	f 28c. Inju	ry at	T	ence 6 Other (Special Company)	ecity)
on	ding th. Afte fune	tior	1 Natural 5 Pending 2 Accident investigatio	(Month	, Day Year)	Injury	Wo	irk?]Yes 2 □ No			
Division	Attendil r death. sctor: A sy the fu	fica	3 Suicide 6 Could not b	28e. Place o	of Injury - At h	ome, farm, st	reet, factory, office			treet and Number or R	ural Route Number,
Ö	al or a after	Certification:	4 Homicide	building	g, etc. (<i>Speci</i> i	fy)			City or Towr	n, State)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	nysician: To the b	est of my kno	owledge, deal	h occurred at the ti	me, date and plac	e, and due to the ca	ause(s) and manner a	s stated.
	he Ho in 24 he Fu	edical	one)	and manne	er stated.	ation and/or ir	ivestigation, in my	opinion, death occ	urred at the time, di	ate and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c. Licen		2	9d. Date signed (Moni	th, Day, Year)
•	c1						15	+422		9-28.05	
	8		30. Name and address of person who		of death (Iter	m 23a) (Type		ud 21	8=1		
	Sta	10	31. Date filed (MSNIS. Pay) Year) 20	32. Re	gistrar's Sign	ature #	MC, (الم مرا	001		
	Registi		SEP 3 0 20	U5	are h	The state of the s					

State of Maryland / Department of Health and Mental Hygieneo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day David Stansbury Remington September 28, 2005 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 32 Gunfalls Garth Nottingham Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) **Funeral** 102M 2□ F 66 216-36-1750 Director 06/06/1939 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d, Inside City Limits 1 Yes 2' No Director Baltimore Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Gunfalls Garth 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Religion al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clergy permit. Pages 1 end 2 should be filk Department of Health and Mental Hy important: If Item 27 is marked other eny injury or other traument. 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Thomas Remington Mary Hannah Kraft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadine Remington/Wife 32 Gunfalls Garth Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sep 29 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland Sne 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on pach line. mode of dying, such as cardiac or respiratory arrest, HACKAGU CARCIALON Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine inding physicien and use as the burial-translt Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant al time of death Year Day 5 Other (specify) Records, P.O. sete hes been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Many er of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due of the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) Registrar's Signature, State

Registrar

0 2005

* 3	E .	Registrar 1. Decedent's Name (First, Middle, L	ast)	- 00	rtificate of D		2. Date of Death	. No.	3. Time of Death
Physici /Media		Edward	L.	Rol	œy Sr.		September	27, 2005 Year	11:45 A
Examir		4a. Facility Name (If not institution, g			4b. City, Town, or Lo	ocation of Death		4c. County of Death	1
		Stella Maris H	ospice		Towson			Baltimo	re
uneral irector		5. Social Security Number 6. 212-05-8254	Sex 7. Age (In	yrs. last birthday 88 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Y January 11	9. Birth Co.	nplace (State or Forei untry) D.
* -		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limit
Department of result and wender tryglene. Important: if item 27 is marked other than. Important: if item 27 is marked other than. Instruction other traumatic event, the Madical Examinat must be notified at ance.	ector	MD Balt	imore	Dunda.	Lk		10-	Cisinan of What Co	1 ☐ Yes 2 🖔 N
23a or	Funeral Director	2031 Paulette Ro	ad Apt 3		21222		109	USA	antry?
eme E	laur	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
ral', or i	d by Fi	1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:			Specify:		Specific	ite
n "natu Medical	Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occupation of kind of work done during DO NOT use retired)	on ing most of working	7	b. Kind of Business/l	ndustry
other than ent, the M	E O	11 years	College (1-401 5+)	Fore	eman			Copper & 1	Brass Co.
rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last Edward L. Robey	st)		18	3. Mother's Name Sarah C		iden Sumame)	
is marked o	-	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and				
m 27 her ti		Edward L. Robey			Paulette R	Road Apt			
ant: ff ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	-	osition (Name of matory or other place) idge Cemete	Septe ery 30,	mber	c. Location - City or 1 [alethorpe	
Import any Inj		21, Signalure of Funeral Service Lic	enser)	ly 3	2 Name and Address of Connelly Fu 7110 Soller	neral Ho	me Of Du	ndalk,P.A.	21222
ysician ledical aminer	5 S	23a. Part. Enter the disease of co- shock, or heart failure. I co- oni Immediate Cause (Final disease or condition resulting in death)	a. LUNG CAN Due to (or as a co	CER	ter the mode of dying, s	such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
in and ial-transit	Examiner	Sequentially list conditions, if any leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
physicia s the bur	cal		d.						
ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delik Month	very Day Year
s been signed b should be deta	þ	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying cause given i	in Part I.		cco use contribute to	the cause of death?
peen	etec								
ate has page 2	Completed						24a. Was an autopsy performed	d? prior to co	opsy findings available ompletion of cause of 2 No
is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		0.4	6. Place of Death			
0 D	: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III 3LI DOA		9 5 ☐ Residence Id. Describe how	e 6 Other (Special	MOSPICE
r: Afte e fune	Certification;	1 ▼Natural 5 □ Pending 2 □ Accident investigate 3 □ Suicide 6 □ Could not	on be 380 Phone of legistre	ar) Injury	Work? M 1 ☐ Yes	2 □ No		et and Number or Rui	- Courte March
÷ ç	Certi	4 Homicide determine	building, etc. (S	oecify)			City or Town, S	State)	
ral Director	1 1	29a. Certifier 1 Certifying F	Physician: To the best of my aminer: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	h occurred at the time, ivestigation, in my opini	date and place, ar on, death occurred	d due to the caus I at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
he Funeral Director	edicai	one)					.)04	D-1 1 1/14 14	
within 24 hours after deam. To the Funeral Director: After th completely filled in by the funeral	Medicai	29b. Signature and title of certifier			29c. License ni		290.	. Date signed (Month)	Day, Year)
within 24 hours after decrease To the Funeral Director completely filled in by th	Medicai	oney	71-			3721 ⁻	290.	. Date signed (Month), $9/27/0$	

DHMH 17 Rev 1/2001

11:45 а.ш.

SEPTEMBER 27, 2005

EDWARD ROBEY

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last	State of Marylar	nd / Depa	artment o		Mental Hy	Rag. No. 2UU	5 3174
>	Physic /Medi Examir	cal	4a. Facility Name (If not institution, give	Dorothy B. R	Rogers	4b. City, Tow Whea	m, or Location of De		ber 23, 200 4c. County of D	05 12:40 A M eath
	Funeral Director		370-30-0070	x 7. Age (In yrs. □ M 2 1 89	. last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 H ays Hours Mi		orth ay, Year) 9.18	Birthplace (State or Foreigr Country) England
	with the Maryland to 28a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10c. Street and Number	ery	ity, Town or Lo	Wheator	de		10g. Citizen of What	•
9036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other then "nature!', or Iteme 23a or 28a-f ehow shi fighty or other traumatic event, the Medical Examination multiled at ADGE.	d by Funeral Director	11.417 Veirs Mill R 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)		merican Indian,
21215-0036	id within 72 h giene. er then "natu , the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation le completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work d DO NOT use re maker	ecupation one during most of w stired)	orking	16b. Kind of Busine Own Ho	
Maryland	should be filed ind Mental Hygis marked other umatic event, I	To Be (17. Father's Name (First, Middle, Last) James Brewster 19a. Informant's Name/Relationship (T)	voe Print)	19b Mailir	ng Address (Str	Janet	Flockha	, Maiden Surname) Tt er, City or Town, State	Zin Codel
	ss 1 and 2 soft Health are Item 27 is		Barbara Blackmer/F	riend 20b. I	14901 Place of Dispo	Saddle	Leaf Ct.	, Draper		020
Baltimore,	permit. Pege Depertment of Important: if eny injury or		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		Cemet	Name and Acobert A	ddress of Facility Pumphres	t. 28, 005 Funeral	_	, Virginia thesda-Chevy
	Physicien: The law requires that the death certificate be executed The second of the attending physician and the contilicate has been signed by the attending physician and the contilicate has been signed by the attending physician and the contilicate has been signed by the attending physician and the contilication of the continuous of the contilication of the con	dical Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	idications that caused the deal ne cause on each line. Dehydrati Due to (or as a consect to a consect to con	th. Do not ento On quence of): Alzhe quence of):	er the mode of	dying, such as cardi			Approximate Interval Between Onset and Death
P.O. Box 68	thet the death certifical today the attending phice detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregna Other (specify			23d. Date of o Month	delivery Day Year
ords, P	w requires thet been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying cause	given in Part I.			to the cause of death? Probably 4 Unknown
al Records,	icien: The law r certificete has be ector. page 2 sh	Completed	25. Was case referred to medical					24a. Was auto perfo 1 — Yes	ormed? prior to death	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
	ding Physicien: h. Atter this certific funeral director.	on: To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. I	0#		one) dence 6 Other (Sp how injury occurred	pecify)
Division	r Attenter deat	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre		I Yes 2 No ce	28f. Location (. City or Tot	Street and Number or wn, State)	Rural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, in m	ny opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
		~	29b. Signature and title of certifier 39. Name and address of person who co	ealso Ph	ysicia.	الم	ense number H0043745	2	29d. Date signed (Mo September 2	
	Sta Registr		Janet Kaye Oneal, 3 Data filed (Month, Day, Year)		oneybro		ve, Kensir	igton, Ma	iryland 2	20895

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryl	and / Depa		Health and N	Mental Hygi	epe 005 31	742
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Helen J.	Shadle	-			2. Date of Death Month Sep	Day Your	ime of Death
	Examin Funeral Director	er	210 34 3303	NUTSING X 7. Age (10)	g Cente vis. last birthday) 13 Yrs.	4b. City, Town, of Selection of			4c. County of Death Anne Aru (Year) 9. Birthplace (Security)	indel
	with the Maryland a or 28a-f show be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD	10c.	City, Town or Lo Baltin					side City Limits Yes 2 ☐ No
)	th with the 23a or 28a	al Director	10e. Street and Number 2130 Harman Ave	9		10f. Zip Code 21 230)	10	g. Citizen of What Country? USA	
920	within 72 hours after death with the Maryland ane. then "neturel", or Items 23e or 28e-f show Ite Madical Examirer must be nailfied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Ind Black, White, etc. Specify: White	an,
Maryland 21215-0036	filed within 72 ho Hygiene. ther then "netuint, Ire Modest	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire nemaker	pation during most of worl d)	king	6b. Kind of Business/Industry Own Home	
yland	ed tal	To Be C	17. Father's Name (First, Middle, Last) James Persinge					ie (First, Middle, Ma ie Humph	,	
	r 25 End		19a. Informant's Name/Relationship (Ty Tina Wright /Frie	end	2130) Harman	Ave Balt:	imore MD		
Baltimore,	of of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 1 Donation 5 □ Other (Specify)	Removal from State	b. Place of Dispo cemetery, cren Loudon Parl	natory or other pla	0ct. 200	1,	Dc. Location - City or Town, St Baltimore MD	ate
Ball	permit. Pag Department Importent: any Injury o		21. Signature of Juneral Service Licens	99	22		ess of Facility Stevens Fl Fort Ave. 1			
	Physician /Medical Examiner		23a. Pant1. Enter the disease of compleshock, or heart failure. Learnly of Immediate Cause (Final disease or condition resulting in death)	ications that caused the done cause on each line. Due to (or as a con	roma .		ng, such as cardiac		to brain Fi	eximate al Between t and Death
4	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
68760,	cate be ex physician s the burial	cai	L.	Due to (or as a con:	sequence or):					
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month Day	Year
<u>α</u>	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not	resulting in the ur	nderlying cause giv	ven in Part I.		cco use contribute to the caus 2 望No 3 ☐ Probably	
Vital Records,	The ate his	e Completed	25. Was case relerred to medical				GC Plant of Date	24a. Whas an autopsy performe	2No 1 □ Yes 2 □ No	n of cause of
of Vi	physicien this certifi al director	To B	examiner?	lospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatien	t 3□ DOA Ott	ner /	h (Check only one) ome 5 - Residen	ce 6 ☐Other (Specify)	
Division o	ding F	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year			ry at rk? Yes 2 □ No	28d. Describe how		
Divi	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certif	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)			City or Town,		Number,
	ne Hos	Medical	29a. Certifier Certifying Physical Check only one)	ner: On the best of my the best of examination and manner stated.	knowledge, death nination and/or inv	occurred at the tile restigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the ca	use(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier Rain S. Kar	upurein	14. D	29c. Licens	6307	290	1. Date signed (Month, Day, Ye	ar)
	1		30. Name and address of person who co	ompleted cause of death (I	(Item 23a) (Type, I) ユ w・M	APLER	D, LIN	THICH	M, HD 2109	0.
	Sta		31. Date filed (Month, Day, Year) SEP 3	32. Registrar's Si	ignature	back				

			1 - For State Registrar	State of Maryland / Dep	partment of Health and leartificate of Death	Mental Hygier	
	表示		1. Decedent's Name (First, Middle, La.	st)		2. Date of Death Month	3. Time of Death
	Physici /Medic		FRANCIS B	STROMYER		SECTEMO	2237200 3:47 M
	Examin	_	4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of Deat	n i	c. County of Death
		g(20)	of HARRIT TR	LATTAL	Towson		3 ALTIMORE
8.	Funeral		5. Social Security Number 6. S			8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		213 PS 1004	XM 2 F 49 Yrs.	Working Days Flours Will.	AUG- 11 19	SO MARYLAND
	۵ ,		Usual Residence of Decedent	10a City Taylor		,	
	show	<u>_</u>	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Be-f	cto		rore lows	00		1 □ Yes 2 No
	ii	Dire	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28e-f show ta Madigal Examirar maral be notified at	Funeral Director	8122 KIRKWALL	LOURT	31386		U-S.A.
	ep .	Ine	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
98	or it	F	1 Never Married Married	1 ☐ Yes 250 No ff Yes, Give	1 ☐ Yes 2 No Specify:		Specify:
21215-0036	urai	d by	3 Widowed 4 Divorced	Year or Dates:			MHIA
5	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ide completed) (Giv	edent's Usual Occupation re kind of work done during most of wo	dina	Kind of Business/Industry
2	han ne	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	D W	+ ILSOAMAZH ZOALLA
	ygie her t		19767	4785 PROF	ZELA LIUVAPE	27	WEAUX, TUE
2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic svent, Ire Ma	Be	17. Father's Name (First, Middle, Last,	,	18. Mothers Nar	ne (First, Middle, Maid	en Sumame)
<u> Xa</u>	should ind Men s marks umatic	2		TROMYER	reless	1 V- SM	HTT
Maryland		10	19a. Informant's Name/Relationship (Type, Print) 19b. Ma.	iling Address (Street and Number or Ru	ıral Route Number, Cit	y or Town, State, Zip Code) 21286
	1 and Health em 27 ither tr		MARY FRANCIS S		LKIRKWALLLOUR	Towor 7	T. HKALAVO
Baltimore,	of H		20a. Method of Disposition Burial 2 Cremation 3	20b. Place of Discometery, or	position (Name of ematory or other place)		Location - City or Town, State
Ĕ	Pages nent of int: if it ury or o		4 Donation 5 Other (Specif			The same of the sa	analysal noosel
E	permit. Pag Department Important: I any injury o		21. Signatur of Fun ta Sarvice Line		22. Name and Address of Facility	REMORIES	2021
Ö	Departiment Department		Jan Vara	_	SECONAREDRO RO	AN PARKU	WE MANYAND 24134
	*		23a. Part1. Enter the disease, or com	plications that caused the death. Do not e	nter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	1.01.		ARCTI	Onset and Death
A	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	IAL INF	Price	9) 4
	Examiner			3 50 10 (0: 40 4 50:150450:150 51).			
		ē	Sequentially fist conditions, if any, leading to initirediate cause. Enter Underlying	 Due to (or as a consequence of). 			
	nsit	in	Cause (Disease or injury				
	be executed siclen and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	a					
87	ate the	dical		_ d			
9 ×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			2010 115
Вох	ath a	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5 9☐ Unknown	Other (specify)		
P.0.	that the death ned by the atter detached for u	P.		contributing to death but not resulting in the	underhing squae quee in Best I	23a Did tobaco	o use contribute to the cause of death?
	signed l d be det	Completed by	H VI	PERTENSI	, ,		
Records,	w require been si should t	ted		TEICH DIST	V/V	1 Tes	No 3 Probably 4 Unknown
Ö	law as b	ple				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The page	Ю				performed	death?
Division of Vital	Physicien: The law this certificate has t ral director, page 2 s	0	25. Was case referred to medical		26. Place of De	ath (Check only one)	
>	yaic is ce direc	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ■ FR/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)
0	g Ph er th er al		27. Manner of Death	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how in	jury occurred
<u>ō</u>	Attending in death. sctor: After by the fune	atic	Natural 5 Pending 2 Accident investigation		M 1 Yes 2 No		
Vis.	Atte	ifi	3 Suicide 6 Could not b	286. Prace of injury - At nome, farm, s	street, factory, office	28f. Location (Street	and Number or Rural Route Number,
ā	al or s afte i Dir d in	Certification:	4 El Homicide	building, etc. (Specify)		City or Town, St	1(0)
	hours nera y fille		29a. Certifier Certifying Ph	nysician: To the best of my knowledge, de	ath occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	(Check only 2 Medical Examone)	miner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, date a	and place, and due to the cause(s)
	To the within Fo the comp	₩	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)
		-	1 Busy	mp	D46494	9	128/2005
. 1	1/2		30. Name and address of person who	completed cause of death (ftem 23a) (Typ	e. Print)		1
İ	U		BINDU NO			F AVE	CIM MOZWOT
1	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature	2 40 -		21286
0.00	Regist		SEP 3 (12)	105 House St A	and a		

			For Stete Registrar	State of Maryla		artment of H tificate of I		ntal Hygien Reg. N	-000	31744
	Physicia		1. Decedent's Name (First, Middle, Las Edward	S	1 Fie	2	$\sum_{i=1}^{2}$	Date of Death Month	24 2 (P)S	3. Time of Death
İ	/Medic Examin Funeral		4a, Facility Name (If not institution, give Mercy 5. Social Security Number 6. So	street and number) Coud To Age (In yrs	w		Location of Death If Under 24 Hrs. 8 Hours Min. 8	Date of Birth (Month, Day, Yea	Sc. County of Deet	hplace (State or Foreign
l,	Director		185-26-6219 1 Usual Residence of Decedent	M 2□F 70	Yrs.	WOMES Days		3-16-1935		nsylvania
	death with the Maryland ms 23a or 28a-f show	_	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he Ma	ecto	MD n/a		Baltimo	10f. Zip Code		100.0	Citizen of What Co	
	3a or	I Dir	1911 Harman Ave.			21230			ited Stat	
	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-1 show solical Examirer mast be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 7/3 1 X Yes. 2 No 7/3 If Yes, Give 7/3/ Year or Dates: 7/3/	10/23		ispanic Origin? (Speci n, Mexican, Puerto Ri Specify:		14. Race - Ame Black, White	nicen Indian,
0500-6171	d within 72 hou glene. ir than "natura ine Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation	16a. Deced (Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	ation furing most of working I)		Kind of Business/	
7	filed Hygi other	e Co	17. Father's Name (First, Middle, Last)		Cook		18. Mother's Name (i			
land		To B	Clinton Silfies				Irene Si	lfies		
lary	2 should and Men is marke	·	19a. Informant's Name/Relationship (7	•		- Harman 10	and Number or Rural F			
e, S	ges 1 and 2 should to f Health and Mer if item 27 is marke or other traumatic		Joseph B. Coulson 20a. Method of Disposition		1925 Place of Dispo	Harman Av	ve. Baltimo		land 212 Location - City or	
Baitimore,	Pages Iment of tant: If it jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			sition (Name of matory or other place ans Fores		,		ls, Maryland
nan	permit. Page Department Important: fl any injury or 20028.		21. Signature of Funeral Service Licen	WWW OV			ss of Facility Ambr ur Spring			, Inc. aryland 21227
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the decone cause on each line. a. Due to (or as Conse	yse	er the mode of dyin	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
Č,	ificate be executed g physician and as the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events resulting in death) Last	c						
x 68/60	ificate g phy as the	Medical	IF FEMALE:	d.						
.О. Вох	s that the death certifined by the attending of detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preging the birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
ords, P	The law requires that the tee hay been signed by thoage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	1		o the cause of death?
Vital Records,		Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
<u> </u>	s certification	o Be	25. Was case referred to medical examiner? 1 Yes 2 Yes	Hospital: 1 patient 2	☐ ER/Outpatien	nt 3 DOA Oth	er: 4 Nursing Home		6 □Other (Soe	c(fy)
n of	ng Phy fter this ineral d	on: To	27. Manger of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		yat 28	d. Describe how in		y)
Division of	f or Attendii after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		home, farm, str		Yes 2 □ No 28	f. Location (Street City or Town, Sta	and Number or Ru ate)	ıral Route Number,
	To the Hospital or Attanding Physici in: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C	(Check only 2 Medicel Exer	lysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death nation and/or in	vestigation, in my o	pinion, death occurred	at the time, date a	and place, and due	o to the cause(s)
)	To To	2	29b. Signature and title of certifier	1 Kinz	21,	29c. Licens	111 FUU	(29d. [Date signed (Monti	- 20 YAL
	3		30. Name and address of person who	completed cause of death (Ite	om 23a) FType, WL	dical (Detter	301 S	t. Ru	e Place
	Sta Regist		31. Date filed (Month, Day, Year) SEP 3 0 2	32. Registrar's Sig	nature	aske				L also

			For State Registrar	State of M	/laryla			nt of H		Mental H	ygien	m m m	017	* i p~
	Physici	20	Decedent's Name (First, Middle)	a, Last)						2. Date of I			3. Time 6	of Death
100	/Media	al	ALBERT 4a. Facility Name (If not institution	JOSEF		S	MIT		Location of De	SEPT	. 22	. 2005 c. County of De	9:43	3 p M
	Examin	- 8.	SOUTHERN MARY 5. Social Security Number	LAND SUBA	CUTE	. last birthday)	C1	INTO			P	RINCE	GEORGE	S
	- Funeral Director	8)	220-30-0054	1 ∑ M 2□F	70	Yrs.	Month		Hours Mi		Day, Year - 193		inthplace (State of Country) LTIMOR	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside C	ity Limits
	a-f sh	ctor	MD PRINCE	E GEORGES	S	PRINGD	ALE						1 X Yes	2 □ No
	with thu	Director	10e. Street and Number 3306 HEIDI	TANE			10f. Z	ip Code	, ,			itizen of What C	ountry?	
	ms 23	Funeral	11. Marital Status	12. Was Deceder	nt Ever in l		Was Dec	2077 edent of Hi	spanic Origin?	(Specify Yes or I	1	U.S.A.	erican Indian.	
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23e or 28e-f show event, the Medical Examinat must be notified at	þ	1 Never Married 2 Marri 3 Widowed 4 Divorced	It Yes Give	□ No		f Yes, sp	ecify Cubai	Specify:	erto Rican, etc.)		Black, Wh		
2	72 ho 'natur	eted	15. Decedent (Specify only highes	i's Education at grade completed)	1949.	- 1 9 5 7 16a. Deced (Give	kind of v	rork done a	uring most of w	vorking	16b. F	Kind of Busines		
121	within 72 iene. then "nat	Completed	Elementary/Secondary (0-12) 1 2 t h	College (1-40	r 5+)	life. I	DO NOT	use retired, RVEYC		•	WA	SHINGT	ON GAS	CO
D	be filed tal Hygie d other event,	Be C	17. Father's Name (First, Middle,	Last)						ame (First, Midd	1		ON GAB	- 00.
aryland	should be nd Menta marked umatic ev	ToE	UNKNOWN						LILL			ULLIVA		
Mar	id 2 sh Ith and Ith and 27 ts m traum		19a. Informant's Name/Relations DELORES A. S							Rural Route Nun				
ē,	es 1 and 2 should to Health and Ment fitem 27 is marked rother traumatic errother traumatic		20a. Method of Disposition			Place of Dispo	sition (N	ame of		SPRIN(L MD ocation - City o		
altimore,	Pages ment of tant: if it		1 Burial 2 Cremation 4 Donation 5 Other (S)			VETE	RANS	CEM	09	-29-05	CHE	LTENHA	M. MAR	YLANI
Ball	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fuperal Service	Jan 20	>	22	!. Name :	and Addres	s of Facility	TAYLOR'	SF	UNERAL	HOME	
8760,	Physician /Medical Examiner phisician and prize phisician and the prize ransil ransil ransil phisician and phisici	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a d. Due to (or a d.	as a conse	quence of):	MAC		IA C	WEA I	(AEF)	ASTICE	S MU	24 H)
.O. Box 68	The law requires that the death certificate be executed to be been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fet	al death 3	Ectopic Other (s	pregnancy specify)				23d. Date of de Month		Year
٥.	res that igned by be deta	by Ph	Part II. Other significant condition	ms contributing to death	but not re	sulting in the ur	nderlying	cause give	n in Part I.	23e. Dio	tobacco	use contribute	to the cause of c	death?
ord	w require been si should I									1[Yes 2	□No 3□P	robably 4 🔼	Jnknown
al Records,		Completed								24a. We aut per 1 Tyes	opsy formed?	prior to death?	utopsy findings completion of c s 2🛣 No	available ause of
Vita		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tient 2	BR/Outpatien	it 3 🗆 🗆	Othe		eath (Check only		2 TO# 12		
Division of	Jing After fune		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of In (Month, D		28b. Time of Injury		28c. Injury Work		Home 5 ☐ Re 28d. Describe			жify)	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 288. Place of I	njury - At h etc. (Spec	nome, farm, str ify)	eet, facto	ry, office		28f. Location City or T	(Street ar	nd Number or R	Bural Route Num	ıber,
	To the Hospil within 24 hour To the Funers completely fills	edicai	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the bes Examiner: On the basis and manner	of examin	owledge, death ation and/or inv	occurre vestigatio	d at the tim	e, date and pla inion, death oc	ce, and due to the	e cause(s e, date an	and manner a d place, and du	s stated. e to the cause(s	;)
	To t To t	Σ	29b. Signature and title of certifier	ſ			6.0	oc. License	·	<u></u>		ate signed (Mon		car.
,	7		30 Name and appress of person	who completed cause of	f death (Ite	m 23a) (Type.	Print)	1-1	001	S VA WO	2010	MINIC	- 22,6	-CED
r			LI MIZOLZA	ARCD. 120	70 1	QUD LI	NE	LEA	TEN U	VALDO	F	Mel-	ZOXX)2_
8 ×	Sta Registi		SEP 3 0	2005 32. Pogis	strar's Sign	ature	sail	,			/			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Gary Sullivan SEPTEMBER 25, 2005 4:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15M 2 F Director 61 218-40-9647 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if Health and Mental Hygiene. Itam 27 is marked other than "naturel", or items 23a or 28a-1 shov other treumetic event, the Madical Examiner must be multified at Md. Harford 1 ☐ Yes 2√ No Completed by Funeral Director Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3215 Canterbury Lane 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "naturel; or iten any injury or other treumetic event, the Medical Examinat ODEs. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I.T. Dept. - State Elementary/Secondary (0-12) College (1-4or 5+) of Maryland Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William B, Sullivan ဥ Dorothy E. Edrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Sullivan/wife 3215 Canterbury Lane, Fallston, Md. 21047 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessops Meth. Ch. Cem. 9/28/05 Sparks, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Md. 21014.

21014. Approximate shock, or heart failure. List only goe cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** a NON SMALL CELL CANCINOMA OF THE LUNG WITH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTASIS TO THE BRAIN ADRENAL GLANDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the Records, P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗌 No 1 ☐ Yes 2X No 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2X No ဥ 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide to the Hospitei Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 25886 30. Name and address of person who co "pleted caus" of death (Item 23a) (Type, Print) LILIA CEBALLOS, 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 |Y|_ D_ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State CANAL ! Registrar SEP 3 0 2005

DHMH 17 Rev 1/2001

				or Print in Black I			•	_	
			1 - State Registrar	te of Maryland / De _l Co	partment of F e <i>rtificate of</i>		ental Hygier	000-	21717
*			Decedent's Name (First, Middle, Last)				2 Date of Death		3. Time of Death
	Physicia /Medic		Calvin Edmon Shento	on, Sr.			SEPTEMBER	Pay X Year	5 2:40 AM
	Examin	er	4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, o	or Location of Death		4c. County of Dea	1
			BALTIMORE WASHINGTON 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	HNNE -	RUNDEL
	Funeral Director		217-16-3622 1ŽM 2E	7. Age (117) 3. 1231 Dillilota	Months Days	Hours Min.	(Month, Day, Yea	(ar) (ar)	thplace (State or Foreign punitry) Syland
			Usual Residence of Decedent				, - F - C - C - C - C - C - C - C - C - C	7 - 1141	yzana
aryla	ehow stat	Ž	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
the N	28a-f	Director	Maryland Anne Arundel 10e. Street and Number	Severn	10f. Zip Code		100	Citizen of What Co	L
with	3a or		41 Burns Crossing Rd.		21144			ited Sta	•
deet	ame 2	Funeral	11. Marital Status 12. Was	S Decedent Ever in U.S. 13 led Forces?	3. Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No-	14. Race - Ame	erican Indian,
safter	ai', or Iteme 23a or 28a-f ehov Exeminer must be natilied at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐	Yes 2 X No es, Give	1 ☐ Yes 2 No		moan, Bro.)	Black, Whit	white
hour	ofural'		3 X Widowed 4 □ Divorced Yea 15. Decedent's Education	r or Dates:	cedent's Usual Occur	nation	166	Kind of Business	
hin 72	nn "ne Medis	plet	(Specify only highest grade compi	leted) (Gi		during most of working	ng Tob.	Kind of Dusiness	midustry
be wit	ntal Hygiene. od other than "natural", or event, it e Medical Exerti	Completed	8	Tele	vision Rep	air Techn		Repairs	
2 should be filed within 72 hours after deeth with the Maryland	Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than any injury or other treumatic event, Ita Ma once.	To Be	17. Father's Name (First, Middle, Last) Ezra Shenton			18. Mother's Name Veronic	(First, Middle, Maid a Dean	en Sumame)	
2 sho	ls m		19a. Informant's Name/Relationship (Type, Prin	19b. Ma	iling Address (Street	and Number or Rura	l Route Number, Cit	y or Town, State, .	Zip Code)
1 and	Health em 27 ther t		Norman Shenton / Son 20a. Method of Disposition		Burns Cros	ssing Rd.		D 21144 Location - City or	Town State
Pages	ont of t: If it y or o		1 Burial 2 Octobration 3 Removal	from State cemetery, c	rematory or other pla	Septer 28,	nber		
permit. P	ortme orten injur		21. Signature of Funeral Service Licensee	Metro Ci	22, Name and Addre	ss of Facility	2005 6	atonsvil.	re, mp
	Deper Impor		MAN SOLL	-	421 Crain	ss of Facility Ruddick Fur Highway	neral Home S.E. Glei	e, P.A. n Burnie	, MD 21061
	-		23a. Part1. Soler the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not e	enter the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	Stroke					Onset and Death
	Medical xaminer		D	ue to (or as a consequence of):					100
		Jer	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequence of):					10 years
xecuted	and I-transit	xamlner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
0	5 6	Ш	resulting in death) Last D	ue to (or as a consequence of):					
The law requires that the death certificate be	attending physiclan for use as the buria	Physician/Medical	d						
certif	nding use a	n/Me		es, outcome of pregnancy				23d. Date of de	ivery
death	the atte	sicia	1 Yes 2 No		3 □Ectopic pregnanc; 5 □ Other (specify) _	<i>y</i>		Month	Day Year
at the	ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributin			-1. P	OZ- Didah		
ires a	signed be de	d by	Tart II. Other significant conditions contributin	g to death but not resutting in the	underlying cause giv	en in Fait i.		3.7	the cause of death?
¥ req	been sig	Completed					24a. Was an	, -	
The la	page 2	отр					autopsy performed?	death?	utopsy findings available completion of cause of
ien:	is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	YO IL TOS	2□ No
hysic	this ce al dire	2	1 ☐ Yes 2 No Hospital:	Impatient 2 EH/Outpat		4 Nursing Hon	ne 5 Residence	6 □Other (Spe	cify)
Attending Physicien:	ath. rr: After th	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time Injury	y Wor	yat k? Yes 2 □No	8d. Describe how in	jury occurred	
el or Atte	after de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	2	Ref. Location (Street City or Town, Sta	and Number or Ru ate)	ura l Route Number,
To the Hospitel or	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (Check only 2 Medical Examiner: On	To the best of my knowledge, de the basis of examination and/or manner stated.	ath occurred at the til investigation, in my o	me, date and place, a pinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
To th	vithir To th comp	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. [Date signed (Mont.	h, Day, Year)
	A		Malea	u MD	Da	059919	7 Se	skuber	-28 2005
	1		30. Name and address of person who completed	d cause of death (Item 23a) (Typ	e, Print)	16 D		1 010	, ,
*	Sta	tě	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 Di,	Slan Bu	MUR, M	D 0<10	6
	Registr		SED 9 1 200E	8	1 1				

P.O.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 26, 2005 9:40 A M Jean K. Schroeder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 1-31-1930 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Min. Days Hours Months 100-24-1760 75 **Director** New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location ?7 Is marked other than "natural", or Items 23a or 286-1 show traumatic avant, It a Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Annapolis Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 802 Coxswain Way, #106 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry A. Pfaff 2 Amelia P. Anton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl R. Schroeder/ Husband 802 Coxswain Way, #106 Annapolis, MD 21401 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any injury or Kalas Crematory ⁴ 4 □ Donation 9-28-05 Edgewater, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 1 Impatient Certification: To 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 Tes 2 No 2 Accident the 1 6 Could not be within 24 hours after dea To tha Funaral Diracto completely filled in by th 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21461 ate Rid Sto 300 MITTES 900 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 2005

			1 - For Stete Registrar		partment of Health and Certificate of Death	Mental Hygier	2005 3171.0			
	Physici	an	1. Decedent's Name (First, Middle, Last)		PRIT	2. Date of Death Month	Day Year 3. Time of Death			
	/Medie Examir	cal	4a. Facility Name (If not institution, give :	street and nymber)	4b. City, Town, or Location of Dea	24 EM	4c. County of Death			
				,	BA/tima	16	W/4			
	Funeral Director		5. Social Security Number 6. Sec 218-44-8036	7. Age (In yrs. last birthda	Months Days Hours Mir		9. Birthplace (State or Foreign Country)			
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location,		10d. Inside City Limits			
	Maryl B-f sho	tor	mo w	/A Bo	altimore		1 Dixes 2 □ No			
	with the	Dire	10e. Street and Number	~ 0.11 10	10f. Zip Code	_	Citizen of What Country?			
	ms 23	Funeral Director	19/9 Laur		2/2 2 3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian,			
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exams for must be codified at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	II Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	no Hican, etc.)	Black, White, etc. Specify: Black			
15-0	in 72 h n "natu ledical	oletec	15. Decedent's Edu (Specify only highest grade	e completed) (G	ecedent's Usual Occupation five kind of work done during most of wi ie. DQ NOT use retired)	orking 16b	. Kind of Business/Industry			
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Laborer		Construction			
Maryland	buld be filed Mental Hygid arked other atic event, II	To Be	17. Father's Name (First, Middle, Last) Robert L.	Shew Sk.	18. Mother's Na	me (First, Middle, Maid Peoul	len Sumame) Shaw			
Mary	d 2 should in and Menit 7 is marked traumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Ma	ailing Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, Zip Code) Q Ala Ala			
	ges 1 and t of Health tf item 27 or other tr	100000	20a. Method of Disposition	cemetani i	sposition (Name of crematory or other place)	Date 20c.	. Location - City or Town, State			
Baltimore,	Pa men ant: ury		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	Bay U	ver Crem 92	8/05/	Berthamere U/1)			
Ball	permit. Pag Department Important; any injury once.	1	21. Signature of Funeral Service Licens		22. Name and Address of Facility (n Road	Balt NO 21206			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.			Approximate Interval Between Onset and Death			
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to r as a consequence of):	dial INFI	ACTIO	N 5 mm/Neute			
В	Examiner	Ļ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):						
Т	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.						
60,	ficate be executed physician and s the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequence of):						
68760,	tificate ig phys as the	ledical								
O. Box	The law requires that the death certificate be executed to the seen signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year			
0	res that the digned by the be detached	by Phy	Part II. Other significant conditions cor	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?			
ords	w requires been sign should be					1 🗆 Yes	2 No 3 Probably 4 Hiknown			
Records,	has be ge 2 sh	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?			
ital		a	25. Was case referred to medical		26. Place of De	1 Yes 2 4	No 1 Yes 2 Abo			
of Vital	d is	ToB	TUPTOS ZUNO	lospital: 1 Inpatient 2 ER/Outpa		Home 5 Residence				
lon	fing Atter	atlon	27. Manner Peath 1 Patural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how in	ijury occurred			
Division	I or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attel completely filled in by the fune	Medical Co	29a. Certifier 1 Certifying Physical Certifier 2 Medical Examination	sicien: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	u(s) and manner as stated. and place, and due to the cause(s)			
	To the within 3	Med	29b. Signature and title of certifier		29c. License number	29d. i	Date signed (Month, Day, Year)			
)	1		DR gol	~ adfin	4 DOO29	9685€	ptem her 22,2005			
	V		30. Name and address of person who co	projected cause of death (Item 23a) (Type Baltaness	pe. Print) STREET/BALT	meste	Date signed (Month, Day, Year) ptem her 22,2005 Mitty/and			
	Sta Regist		31. Date filed (Month, Day, Year) SEP 3 0 2005	32. Registrar's Signature	and the second					

			1 - For State of Maryland / Dep	artment of Health and M		2005 31750					
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death					
	Physici /Medic		Harold John Sussman		Septembe	r 29,2005 5:30 A M					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			603 Teaberry Avenue	Edgewood		Harford					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birthplace (State or Foreign Country)					
	Director		213-20-1700 44 74		July 1,1	931 Maryland					
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits					
	/any	5	Maryland Harford Edgewood			1 ☐ Yes 2 ☒ No					
	28a-	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?					
	with Sa or	₫	603 Teaberry Avenue	21040	1	U.S.A.					
	death with the Maryland ms 23a or 28a-f show rinnst be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,					
٥	or ita		1 ☐ Never Married 2 ☑ Married 1 ☑ Xes 2 ☐ No		Rican, etc.)	Black, White, etc.					
2-003p	d within 72 hours after death with the Marylan liene. r than "natural", or itams 23s or 28s-1 show the Medical Executor traft to notified at	d by									
ק	72 h	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	161	b. Kind of Business/Industry					
7	within lene. than "	Ig.	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)							
Z	lled v lygie her ti nt, th	To Be Cor	17. Father's Name (First, Middle, Last)			Textiles					
and	be filed htal Hyg ad other evant,			18. Mother's Name		,					
5	should b nd Menta markad imatic e		William Sussman 19a. Informant's Name/Relationship (Type, Print) 19b. Mail			ta Tuckerman					
Mal	d 2 sl th an 7 ls r traur			ing Address (Street and Number or Rura Ceaberry Avenue, Ed							
	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 is marka any injury or othar traumatic once.					C. Location - City or Town, State					
altimore,	Pages nent of int: If it		1 Buildi 225 Cremation 3 Bremoval non State	i							
	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A.								
ä	Dep Imp any		Malale Jellan So	Bruzdziński 1407 Old Eagtown Au	Funeral 1	Home, P.A.					
	#.		23a. Part1. Enter the disease, or camplications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest,	sex, Maryland 21221 Approximate					
	Pnysician	ŀ,	Immediate Cause (Final Prince of Control of								
	/Medical		disease or condition resulting in death) a								
	Examiner	L	Sequential list conditions b.								
	D ==	ner	Sequentially list conditions, b.								
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events c. Pue to (or as a consequence of):								
Ď,	ate be executed hysician and the burial-transit	Ü	Due to (or as a consequence of):								
04/80	physic	dicai	d								
Š Q	death certificate e attending phys id for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		_	23d. Date of delivery					
X Q Q	atten for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							
o.	the de y the ched	ysic	1 Yes 2 No 4 Pregnant at time of death 5[9 Unknown								
S,	requires that the de een signed by the a rould be detached f	by Pr	Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.	23e Did tobac	co use contribute to the cause of death?					
202	quires n sign				Yes Yes	2 No 3 Probably 4 Unknown					
ecord	> 0 to	ompleted			24a. Was an	24b. Were autopsy findings available					
r	9 4	mo			autopsy	prior to completion of cause of death?					
Vital	ician: Th certificate rector, pag	e C	25. Was case referred to medical	26. Place of D with	1 Yes 2 Check onlone	No 1 Yes 2 No					
	d is	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other		e 6 Other (Specify)					
ס ר	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Injury) 28b. Time of In		8d. Describe how i	njury occurred					
200	andii eath. or: A the fu	catio	2 Accident investigation	M 1 Tes 2 No							
UIVISION	al or Attanding F s after death. I Diractor: After d in by the funera	ertification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)					
_	urs al aral D	O									
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier Certifying Physician: To the best of my knowledge, deal (Check only 2 Medical Examiner: On the basis of examination and/or in one)	th occurred at the time, date and place, a evestigation, in my opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
	To tha within 3 To tha comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)					
	F 3 F ŏ		Hickory L. / (1848) 200 D36814 9/30/05								
	11		30. Marije and address of person who completed cause of death (Item 23a) (Type, Print) Herrical L. + (IIS) I.g. IM, D. 1505 OS (Or DR. Suite 302 700000 MDZ 1704								
	10,00		Hereire L. Huslig M.D. 7505	OSOr DR. SuinE	3027	12512 CM NOSIDAL					
	Sta	te	31. Date filed (Month, Day, Year) SEP 3 0 2005		,	7					
	Registr	ar	SET 3 V ZUUS								

		·	For State Registrar Amen		#26 Per F	iryland H G84	17 Depa 1 7 9/9	artment o	f Health and of Death		Reg. N		31751
	Physicia /Medic		Decedent's Name (First, Middle, Last) MARY			SIBBL	.E	2. Date of D	27	2005	3. Time of Death		
	Examin	-	4a. Facility Name (If not in	-					•			4c. County of Death	
			STERLING H 5. Social Security Number			a (In vrs. la	st birthday)	BALTIN If Under 1 Yo		· 8 Date of Bi	rth	N/A	place (State or Foreign
	Funeral Director		217-32-8355 1 Months Days Hours Min. 06/09/1907							mtry) MD			
	show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits		
	ours after death with the M ral', or Items 23a or 28a-f Esaniner must be notilli	Director	MD	N/A		BALT	IMORE						1½ Yes 2 □ No
			10e. Street and Number 7003 PARK	HEIGHT	C VALUILE			10f. Zip Coo 212			10g. C	itizen of What Cou	ntry?
		Funeral	11. Marital Status	IILIGIII	12. Was Decedent B	Ever in U.S	i. 13. \		of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or N	0-	14. Race - Ameri	
920		by	1 ☐ Never Married 3		Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	10		1 Yes, specify (to Hican, etc.)		Black, White, Specify:	HITE
21215-0036		Completed							16b. I	. Kind of Business/Industry			
212	2 should be filed within 72 h and Mental Hygiene. is marked othar than "natu aumatic evant, Ibe Medical	Somp	Elementary/Secondary 4	(0-12)	College (1-4or 5	+)	OWI					LIQUOR S	TORE
Maryland	I be file ntal Hy ed othe	Be	17. Father's Name (First,	Middle, Last)		DE	SNICK		18. Mother's Na	me (First, Middle	e, <i>Maid</i> e	n Sumame)	ιΛN
IZ Sign	d 2 should be th and Mental 17 is marked c traumatic eve	은	SAMUEL 19a. Informant's Name/F	Relationship (T)	rpe, Print)	KL		ng Address (Sti	reet and Number or R	ural Route Numb	oer, City		
_	C/ 40 = 60		ROSYLN MAI			2			EIGHTS AVE				
Baltimore,	o Jo		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cre 1 4 🗆 Donation 5 🗆	mation 3 🗆 F		CO.	metery, crer	sition (Name of natory or other N-CHIZU	_{place)} K AMUNO 09	Date /29/200		LOCATION - City or To	
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral						STERSTOWN				
	Physician /Medical Examiner	lner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
			Immediate Cause (Final disease or condition resulting in death)	_	a DANCA	eanc	CAN				_		Onset and Death
			Que to (or as a consequence of):								•		
11.			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
4	execute and al-trans	Examiner											
68760	icate be executed physician and s the burial-transit	edical E			d								
_	entifica ding ph		IF FEMALE:		23c. If yes, outcome	of pregnan	101						
Box	death certifi attending I	Physician/N	23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 No	Inani	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregn Other (specif)				23d. Date of delive Month	ery Day Year
P.O.	at the	Phys	9 Unknown		9□ Unknown					00. 5:4			
Division of Vital Records,	w requires that the death cert been signed by the attendin should be detached for use.	by	Part II. Dther significant	conditions co	ntributing to death bi	ut not resul	tting in the u	nderlying causi	given in Part I.			use contribute to t	he cause of death?
eco	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To tha Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed								24a. Wa:	psy	prior to co	opsy findings available ompletion of cause of
ᆱ										1 ☐ Yes	ormed?	o death?	2 □ No
V.	siciar certif irecto	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 📉 No	-	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatier	nt 3□ DOA	26. Place of De Other: 4 ☐ Nursing H	ath (Check only		6 X Other (Specia	WILLOCD T.C.E.
Jo r	g Physier this	on: To	27. Manner of Death	Pending	28a. Date of Injui (Month, Day		28b. Time of		Injury at Work?	28d. Describe			MUSPICE
sioi	itandir Jeath. tor: Al	catle	2 Accident	investigation Could not be				М	1 Yes 2 No	29f Location	/Stroot a	nd Number of Dur	al Davida Alumbar
Divi	after de Direct	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								ai Houte Number,		
	To the Hospital or Attanding Physician: The lawithin 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)	Certifying Phy Medicel Exem	rsicien: To the best iner: On the basis of and manner sta	examinati	vledge, deatl on and/or in	h occurred at the vestigation, in r	ne time, date and place my opinion, death occ	e, and due to the urred at the time	cause(s	s) and manner as s nd place, and due to	stated. to the cause(s)
	To the within To the Compli	₹	29b. Signature and title	of certifier					cense number			ate signed (Month,	
	^1		1/m	m				()	733974		9	128/05	
	4		30. Name and address of ARN		ompleted cause of d	leath (Item	23a) (Type,	Print)	933974 An Bo	16. M.	1	223	
	Sta	ate	31. Date filed (Month, Da	ay, Year)	32. Registr	ar's Signat	ure	B. B	JVC 199	1 100			
	Regist	rar	SEP 3	0 2005	Red of s	5.35	100	Service .					

			For State Registrar	State of M		partment of ertificate of		and Mental Hy	giene Reg. No. 0 0 5	31752
	Physicia	an	1. Decedent's Name (First, Middle, L		2. Date of De Month		3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, g		nn Shifflet	4b. City, Town,	or Location of	Sept Sept	ember 24, 20 4c. County of	05 3:15 p.m.
	Examin	CI.		8949 Wrightsm				Woodstock		Baltimore
	Funeral			Sex 7. A	ge (In yrs. last birthda)	y) If Under 1 Yea Months Day:		24 Hrs. 8. Date of Bir Min. (Month, Da	th y, Year)	Birthplace (State or Foreign Country)
	Director		216-26-2071 Usual Residence of Decedent		66 ^{rrs.}			January :	10, 1939	Maryland
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar	ctor	Maryland B	altimore			Woodsto	ck		1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 8949 Wrightsmill Rd.			10f. Zip Code			10g. Citizen of Wha	at Country?
	ns 23e	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13	3. Was Decedent of		163 igin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Race -	U.S.A. American Indian,
9	ours after death with the Marylar ral', or Items 23e or 28a-f show Examitrer mat be confifted at	Fun	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	? (No	If Yes, specify Cu				White, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther then "natural", or Items 23e or 28e-f ehow ent, Ite Medical Examiner must be mailified a	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	White
-	in 72 l	olete	15. Decedent's (Specify only highest of	rade completed)	(Giv	edent's Usual Occi ve kind of work don . DO NOT use retir	e durina mos	t of working	16b. Kind of Busin	
212	filed within Hygiene. other then	To Be Completed	Elementary/Secondary (0-12) 12	College (1-4or	5+)	Н	omemake	er	C	wn Home
			17. Father's Name (First, Middle, La				18. Mothe	er's Name (First, Middle,	Maiden Sumame)	
Maryland			Williai 19a. Informant's Name/Relationship	n Lee Cody	10h Ma	iling Address (Strong	at and Alumbi	Laura er or Rural Route Numbe	Katherine Ne	
ā Z	0 0 0		Mr. Cecil E. Shifflet			,		Woodstock, Mar		ne, <i>21p</i> Code)
a)	is 1 and of Health item 27 other to	li	20a. Method of Disposition		20b. Place of Dis		I	Date Date	20c. Location - Cit	y or Town, State
	Pages nent of ent: If it ury or o		1		•	Shepherd Cer		09/28/2005	Ellicott	City, Maryland
Balt	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Price Lo	The Priod.		22. Name and Add	ress of Facili			
	703 8 Q		Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death							
	Pnysician		immediate Cause (Final	ly one cause on each		c (3)	v~Ps	1 L		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence of):	C CC	100	4	7,2	
	Examiner	_	Sequentially list conditions. Sequentially list conditions. Due to (or as a consequence of):							
7	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ď	execu an and rial-tra	Еха	resulting in death) Last	Due to (or a	s a consequence of):					
8760	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical		d						
9 xo	leath certifica attending ph I for use as t	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy				23d. Date o	f delivery
<u>m</u>	death e atter	Physician/Me	in the past 12 months?	4☐Pregnant a		B □Ectopic pregnan □ Other (specify)			Month	*
о. О	that the de led by the a detached f	Phys	9 ☐ Unknown	9□ Unknown			i Post	22° Dida		ite to the cause of death?
ds,	ires tha signed d be del	by	Part II. Other significant condition	Arcol & C	Olesta	11 Cleve	2 Dc	eluconova	A)	Probably 4 Unknown
Records,	w require been si should I	Completed				a	ا عاد	24a. Was	an 24b. Wei	re autopsy findings available
Re	rsicien: The law s certificate has b lirector, page 2 s							autor perfo	rmed? dea	r to completion of cause of th? Yes 2□ No
Vital		Bec	25. Was case referred to medical examiner?					e of Death (Check only o		
of \		To :	1 ☐ Yes 2 No	Hospital: 1 Inpat		BILL 3 DOA		ursing Home 5 Resident	dence 6 Other ((Specify)
Division of	Attending Physicien: or death. ector: After this certification in the funeral director.	tlon	1 Natural 5 Pending 2 Accident investiga	(Month, D	ay Year) Injury	/ W	ork? □ Yes 2 □		ion injury occurred	
	or Attending Fatter death. Director: After in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 28e. Place of It	njury - At home, farm,	street, factory, offic	0	28f. Location (S		or Rural Route Number,
	ospitel or A hours after unerel Directly filled in by		CO. Continue de Continue	Dharisian Tartaka	A = 6 = 1					
	I 4 IL 0	Medical	29a. Certifier Certifying (Check only one)	aminer: On the basis and manner s	of examination and/or	investigation, in my	time, date an opinion, dea	nd place, and due to the ath occurred at the time,	date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		_	29c. Lice	nse number		29d. Date signed (A	Month, Day, Year)
)			• 1	cewest		Do	5211		4/26/	73
	12		30. Name and address of person with	KAWATA	death (Item 23a) (Typ	o, Print)	5 Drie	le Sicil	2:19/	H D 21117
	Sta		31. Date filed (Month, Day, Year)	2005 32. R60	's Signature	1.0.		J		
	Regist	rar	OLI U (2000	Bur St	MOSAGE!				

			1- State of Marylan		artment of H		d Mental Hyg	iene .g. 2005	31753
	Physic		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Dav Yea	
	/Medi Examir		John Francis Sikorski 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	09/25/	4c. County of De	4:00 P M
			Anne Arundel Medical Cent		Annapo	1is		Anne A	rundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 127-09-4841 88		If Under 1 Year Months Days		lrs. 8. Date of Birth (Month, Day, 05/30/	Year) 9. B	irthplace (State or Foreign Country) NY
			Usual Residence of Decedent				03/30/	1917	
	Aaryla f show	ō		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28e-i	Director	MD Anne Arunde1 Pa	saden	a 10f. Zip Code		10	0g. Citizen of What (
	th with	ai D	7749 Edgewood Avenue		2112	2		U.S.A.	,
980	hours after death with the Maryland turel', or Items 23e or 28e-f show II Ever, it we frough by	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No 194 If Yes, Give Year or Dates: 194	0-	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
21215-0036	0 0	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	ition	vorking 1	16b. Kind of Busines	s/Industry
121	within 7 jiene. r then "n	idmo	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done a OO NOT use retired,			MD CL - L	
	Hyg Hyg artha	Be Co	12 17. Father's Name (First, Middle, Last)	Sup	erinten		lame (First, Middle, M	MD State Maiden Sumame)	9
Maryland		ToB	John Sikorski			Victo	ria Ptas	zynski	
Mar	d 2 should th and Mer 7 Is marke treumatic		19a. Informant's Name/Relationship (Type, Print)	1			Rural Route Number,		
	1 an Heal em 2 ther		Elsie Sikorski / Wife 20a. Method of Disposition 20b. P	/ / 49 lace of Dispos	Edgewo	od Ave	nue, Pas	sadena, I	
Ë	Page ient o nt: If		1 23 Contain C Contained Contained Contained			1	/29/05		
Baltimore,	permit. Page Deportment of Importent: If any injury or once:		21. Signature of Funeral Service Licensee	22.	Name and Address	s of Facility	J.Gonce	Funera	l Home, PA
	0 □ = 41 Ol		23a. Part1. Enter the disease, or complications that caused the de the	1	69 Rivi	era Dr	ive, Pas	adena, 1	
	Priysician		Immediate Cause (Final		-	, such as card	iac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Jence of):	101/Le	,			days
1	Examiner	_	Sequentially list conditions, b.	psis					days
7	uted	Examiner	Sequentially list conditions, if any, leading to immediate class a fine in any inc. Cause (Disease or injury	tonce of):	F.O.	n.t.			
ó	eath certificate be executed attending physician and for use as the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequ	ence of):	1000	san	1)		years
8760,		dicai	a. Gron	ary	arten	y de	sease)		years
9	certific ding p	/Mec	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome of pregnant	nev		U			
.O. Box	The law requires that the death certific tie has been signed by the atlending p page 2 should be detached for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	death 3 1	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Records, P.	w requires that been signed I should be det	ed by P	Part II. Other significant conditions contributing to death but not resu	Ilting in the und	derlying cause give	n in Part I.			o the cause of death?
_	: The law r cate has be ; page 2 sh	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 UN0 Hospital: 1 I Innatigat 2 1		Other		eath (Check only one)	_	
Division of	r Attending Phy ter death. rector: After this by the funeral d	\vdash	Construction of the constr	ER/Outpatient 28b. Time of Injury	28c. Injury	4 Nuising	Home 5 Residen 28d. Describe how		city)
Divis	itel or Atternations after de Infectoried in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify,)			City or Town,	,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my know 2 Medicel Examiner: On the basis of examination and manner stated.	vledge, death on and/or inve	estigation, in my opi	nion, death occ	curred at the time, date	e and place, and due	to the cause(s)
			Hung Lavis MD		-	31//	290	d. Date signed (Mont	O S
l	OFI		30. Na e ind address of erson who completed cause of death (Item Hun J. Davis MD		rint) edical !	Carleson.			73.403
	Sta		31. Date filed (Month, Day, Year) 32. R trar's Signati	1LB		ainwa	y Annap	ULIS, MI	21403
	Registra		SEP 3 0 2005	K A	anti _				
DHI	/IH 17 Rev 1/20	U1		- 4					

ORIGINAL

			1 - State of Ma	aryland		artment					gien Reg. Ni	Z H H 5	317	54
		东	Decedent's Name (First, Middle, Last)							Date of Dea	ath		3. Time of	Death
	Physicia /Medic		ALBERT			SNYD	ER		<	Soften	Da Da	27 Zox	5 103	BY PM
	Examin	er	4a. Facility Name (If not institution, give street and number)			2	1 1.	Location	. 1	100	40	c. County of Dea		
	Funeral			e (In yrs. la	ast birthday) If Under	1 Year	If Under	24 Hrs. 8.	Date of Birt	th	9. Bi	N/A thplace (State of	or Foreign
7 8	Director	ŭ I	165-12-2090 ¹₹M 2□F	83	Yrs.	Months	Days	Hours	Min.	5/21/	1927	2	MD MD	
106	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation					<u> </u>		10d. Inside C	ity Limits
500	the Marylar 28a-f show notified at	tor	MD N/A	B.	ALTIM	ORE							1 Yes	2 🗆 No
V	th the or 28s	Director	10e. Street and Number			10f. Zip	Code				10g. C	itizen of What C	ountry?	
t	death with the Maryland ms 23a or 28a-f show r must be notified at	rai	3809 BELLE AVENUE		_		216					U.S.A		
20	or fte	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Nyear or Dates:		S. 13.	Was Deceding If Yes, special	ify Cuba	ispanic Or in, Mexica Specify.	n, Puerto Rio	y Yes or No can, etc.)		14. Race - Am Black, Wh Specify: W		
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)		(Give	edent's Usua e kind of wor	k done d	during mos	st of working		16b. l	Kind of Busines	/Industry	
195 A/	within ene. then '	Completed	Elementary/Secondary (0-12) College (1-4or 5	;+)	MOV	DO NOT usi ER	e retirea	1)				MOVIN	3	
COUNT ryland 2	e filed al Hyg l other vent,	BeC	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (F	irst, Middle,	Maide			
KOW.	ould b Ments marked maric e	To	ABRAHAM			TEIN		LE					NYDER	
Mar	d 2 sh th and th and treum treum		19a. Informant's Name/Relationship (Type, Print) YINKA OGUNSOLA / CASE WORKE	- P	19b. Mail	Ing Address	(Street a	and Numb	er or Rural E NW∆V -		er, City TM∩I	or Town, State, RE, MiD	<i>Zip</i> Code) 2 122Δ	
ie 5	s 1 and Heal	9	20a. Method of Disposition	20b. PI	lace of Disp	osition (Name ematory or oti	e of	1	Date			ocation - City o		
2,ting	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		-	REE BU			09/29/	/2005	BA	LTIMORE	, MD	
Patimore,	permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mantal Highsiene. Important: Il flam 27 is marked other than "natural", any injury or other treumatic event, the Modical Exagence.		21. Signature of Funeral Service Licensee	>		22. Name and 8900 R			20L			& BROS		208
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each life.	l the death ne.	n. Do not er	nter the mode	of dyin	g, such as	cardiac or re	espiratory ar	rrest,		Approximat Interval Bet Onset and	ween
(A)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Preumo Due to (or as		ionaa af):									
	Examiner		Chante			1c P.1	C D	20.00	Disco	c.				
16/ 3	p H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequ	uence of):		7.7.	1						
6	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a consequ	uence of):									
	cate be e physician the buris	dical E	d											
.89	rtificat ng phy s as th	Medi	IF FEMALE:											
.O. Box	Attending Physician: The law requires that the death certific reast. - death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel	death 3	□Ectopic pre □ Other <i>(spe</i>						23d. Date of de Month		Year
٥,	es that the interpretation of the detac	by Pr	Part II. Dther significant conditions contributing to death b	ut not resu	ulting in the	underlying ca	use give	en in Part	1.	23e. Did to	obacco	use contribute	o the cause of o	Jeath?
ord	w require been sig should b		Corney Arty Dises						_	101	Yes 2	!□No 3 1 F	robably 4 🗆	Jnknown
Division of Vital Records, P.O.	ding Physician: The law in the law in the law in Affer this certificate has but funeral director, page 2 st	Completed	Denestia									prior to death?	utopsy findings completion of c s 22 No	available ause of
Vita	sician: Th certificate rector, pag) Be	25. Was case referred to medicat examiner? 1 Yes No Hospital: 1 Inpatie		5010		. Oth		e of Death (C					
of	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Inju	iry	28b. Time		Bc. Injun Worl	y at		5 L Resid		6 □Other (Sp	ecify)	
sior	Attending F death. ctor: After y the funer	atio	2 Accident investigation	y 16a//	Injury	М		Yes 2 □]No					
ivi Vi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, s	treet, factory,	, office		28f	Location (S City or Tov	Street a vn, Stat	nd Number or F e)	tural Route Num	ber,
_	spital hours maral y filled	alC	29a. Certifier 1. Certifying Physician: To the best	of my know	wledge, dea	th occurred a	at the tin	ne, date a	nd place, and	d due to the	cause(s	s) and manner a	s stated.	
	the Ho	ledical	(Check only 2 Medical Examinar: On the basis o and manner sta	i examinat ated.	tion and/or ii				ath occurred					,)
	To To	Σ	29b. Signature and title of certifier			290.	License	e number	00			ate signed (Mor	, , , , , , ,	
	(30. Name and address of person who completed cause of c	leath (Item	23a) (Type	, Print)	00.	563	00		2pl	nop	0 /00	>5
	\		Chandrash A. Stylet	N.	2-0.	Sin	5	Horo	itap.	2B	17	1790		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registr	ar's Signat	ture	Conti	9			ν		•		
Mr. Jak	3.09.0		SEP 3 0 2005	AP and	(4)" (A)	A STATE OF THE PARTY OF THE PAR								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#15, perfff, C848, 10/18/05 TT
State of Maryland / Department of Health and Mental Hygiere 15

		Amend item//15 1 - State Registrar 1. Decedent's Name (First, Mide			rtificate of D			eg. No.		756
Physicia	an	Laura	Marie	Thornto	าท		Septembe	Day	Year	9:45A
/Medic Examin		4a. Facility Name (If not instituti			4b. City, Town, or I		Deptend	4c. County		7:43A
-Xaiiiii	eı	11 1/2 Greenwo	•		Baltimo	ore		Balt	imore	
uneral irector		5. Social Security Number 215–98–2749		Age (In yrs. last birthday) 23 Yrs.			8. Date of Birth (Month, Day, October 2	Year) 1 , 1981	9. Birthplace Country) MD.	e (State or Forei
3 22		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. City, Town or Lo	ncation				10d	Inside City Limi
sa-f sho	ctor		timore	Nottin						1 □ Yes 🌠 N
23a or 24 st be no	ai Dire	10e. Street and Number 8702 Blairwood	d Road Apt	A3	10f. Zip Code 21236	5	1	0g. Citizen of V USA	Vhat Country?	
of other than "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Ma	. If Yes, Give	Xv₀	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	American I k, White, etc.	
tural',	ed by	3 Widowed 4 Divorce	ent's Education		dent's Usual Occupat	tion		16b. Kind of Bu		Try.
A Pagin	Completed	(Specify only high	lest grade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of worki	ing]	Baltimo:		
ther than	E	Elementary/Secondary (0-12)	4 years		lation Ass	sistant		Public 1		_
marked other than imatic event, It e M	Be C	17. Father's Name (First, Middle	e, Last)			18. Mother's Name		Maiden Sumam	е)	
arked o	10 0	Frederic Hami	lton			Sandra	Wagner			
27 Is m r traum		19a. Informant's Name/Relation Frederic and San		Parents 11 1	ng Address (Street ar /2 Greenwo					
Important: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation			osition (Name of matory or other place of Faith (er 3,	20c. Location -		State
Important: I any injury o once.		*4 □ Donation 5 □ Other 21. Signature of Funeral Service		00 2	Conneil Address	ซีก็ฮ์ซัลl H	ome Of 1		, P.A.	
틃검		23a. Part 1. Enter the disease shock, or heart failure.	- C. Cor	mely	7110 Solle	ers Point	Road,	Dundalk		21222 eproximate erval Between
physician and the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Resolute to (or Due to (or C. Resolute)	as a consequence of as a consequence of):	Adero e Endome	ire	a fo	,		mend Death
ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖼 No 9 □ Unknown		n 2 Fetal death 3[t at time of death 5[□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of delivery onth Day	y Year
90	by	Part II. Other significant cond	itions contributing to deat	h but not resulting in the u	inderlying cause give	n in Part I.	23e. Did tol	pacco use contr		ause of death? 4 □Unknov
certificate has been si irector, page 2 should I	Completed						24a. Was a autops perform	ned?	rior to comple leath?	findings availab ation of cause o
After this funeral d	Certification; To Be	3 ☐ Suicide 6 ☐ Cou	Hospital: 1 Inp 28a. Date of 1 (Month, stigation		of 3 DOA Other	at ?	n (Check only on me 5 ☐ Reside 28d. Describe ho 28f. Location (Si	ence 6 V Other		Parents House
ral Dirac		4 Horricide	building	, etc. (Specify)			City or Towi			
une ∑	Medical		ying Physician: To the be al Examiner: On the basi and manner	s of examination and/or in						
BB F	N N	29b. Signature and title of certi	fier	6.1	29c. License			9d. Date signed		
To the Funeral Director: completely filled in by the	_				5.71	10 1		-	7	7
To the Funeral Completely filled		1 Wille	am 1. 1h	Luis M	016	861		JEPT	20	200
To the F		30. Name and address of person 9/03 Fran	on who completed cause	of death (Item 23a) (Type		1861 to Ba	l to mor	- Mi	0 21	218

Amend item#1, perMD G847, 9/30/05 TT State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Brandon Elija Taylor Month 3:00 PM **Physician** ÖS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b_City, Town, or Location of Death **Examiner** of Maryland 13altimore Ba Itimorp MD university If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-14-05 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** Days Hours MD Director N/AUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or items 23e or 28a-f show Examinar must be notified at 1 Yes 2 No Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1714 PIN OAK ROAD Completed by Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
nn: If item 27 is marked other than "neturel; or Iten ury or other traumatic event, ITEM MAJICAL EVENTING. 1 ☐ Yes 2 ▼ No If Yes, Give X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be BOBBY LEON TAYLOR MELISSA ANNE CLARK ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 PIN OAK HOAD FALTIMORE, MD 21234
of Disposition (Name of Date 20c. Location - City or Town, State MELISSA ANNE CLARK/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition perrit. Pages 1 Dep riment of H Importent: If ite any injury or ot once. tX Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE CEMETERY 10/1/2005 PIKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Se vice Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. cardiorespiratory Immediate Cause (Final 24 hours **Physician** disease or condition resulting in death) /Medical prematuriti days Examiner Sacuality is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is intended as our injury Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No has 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 THomicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09-23-05 D0061011 DUY 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) South Greene St, Baltimae MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Sporte SEP 3 0 2005 Registrar

			1 _ State	te of M	aryland / Depa	artment of I		, ,	71111	5 31758
	Physici /Medic		Registrar 1. Decedent's Name (First, Middle, Last) BRIEANNA ASI	HEY	TAYLO		Dealli	2. Date of Death Month	ng. No.	3. Time of Death
	Examin Funeral		4a. Facility Name (If not institution, give street Liniveretty of Maylay 5. Social Security Number 6. Set	d NEd	e (In yrs. last birthday)	Baltin If Under 1 Year Months Days	or Location of Death Or-C If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of N/A Year)	Death Birthplace (State or Foreign Country)
	Director ≥		N/A Usual Residence of Decedent 10a. State 10b. County	2 .	10c. City, Town or Lo	10		9/14/20	05 I	10d. Inside City Limits
	he Maryla 28a-f sho ctifled a	Director	MD BALTIMORE		,	RKVILLE				1 ☐ Yes 2 XNo
	with 1		10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	.t Country ?
	ath v	La	1714 PIN OAK ROAD			21234			USA	
36	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or Items 23a or 28a-f show event, it a Modical Examinal must be notified at	by Funeral	An 1 X Never Married 2 Married 1 [is Decedent ned Forces?]Yes 2 💥 'es, Give ar or Dates:	No	Was Decedent of f Yes, specify Cut 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spe pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. BLACK
ŏ	2 hou		15. Decedent's Education		16a. Dece	dent's Usual Occu	pation	1	6b. Kind of Busin	
21215-0036		Completed	(Specify only highest grade complete in the co	ilege (1-4or	life.	DO NOT use retire	during most of worki	ng	N/A	
	illed Hygid other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M		
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, I	To	BOBBY LEON TAYLOR				MELISSA	ANNE CL	ARK	
ar	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Pr	int)	19b. Mailir	ng Address (Stree	t and Number or Rura	l Route Number,	City or Town, Sta	ite, Zip Code)
	and 2 eelth m 27 i		MELISSA ANNE CLARK/MC	THER	1714	PIN OAK	ROAD BAL	TIMORE,	MD 2123	14
Baltimore,	- I 2 Z		20a. Method of Disposition 1. ☑ Burial 2 ☐ Cremation 3 ☐ Remove 1. ☑ Donation 5 ☐ Other (Specify)	al from State	20b. Place of Disponsional DRUID RII	natory or other pla	ice)		Oc. Location - Cit	
Balt	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	Hay				JOHNSON	FUNERAL	, НОМЕ, Р.А. 21286
Sept.	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complication hock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	Seve		ratory Inter	Distre	- 0	ndrom	Approximate Interval Between Onset and Death
8760,	the death certificate be executed y the attending physician and tched for use as the burfal-transit	dlcal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(a consequence of):		with		17211	4
89	ificate g phy as the	edic	J				- 1		17.	
.O. Box	that the death certific ad by the attending p detached for use as	Physician/Me	in the past 12 months?	Live birth		Ectopic pregnanc Other (specify) _	ry		23d. Date o Month	f delivery Day Year
<u>α</u>	es that gned b	by	Part II. Other significant conditions contributions Severe meta	or to death b	out not resulting in the u		ven in Part I.	23e. Did toba		te to the cause of death? Probably 4 Unknown
I Records,	The law ate has b page 2 st	Completed	Respiratory	fail	we			24a. Was an autopsy perform	prio dea:	e autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	1.		0	26. Place of Death	(Check only one)	
	shys this	2	1 192 5 140	1 Minpatii		1 3 DOA			nce 6 Other (Specify)
n		lo	Tarana a Carana	. Date of Inju (Month, Da	y Year) 28b. Time of Injury	Wo	ryat irk?]Yes 2 □No	28d. Describe how	w injury occurred	
Division of	l or Attending efter death. Director: After i in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	. Place of In building, et	ury - At home, farm, str c. (Specify)		-	28f. Location (Stre City or Town,		or Rural Route Number,
_	Hospita 4 hours Funeral ely filled	edical Co	29a. Certifier (Check only onl) 1 Certifying Physician 2 Medical Examiner: O ar	To the best n the basis o	f examination and/or in:	n occurred at the treatment occurred at the treatment of the treatment of the treatment occurred at the treatment occurred	ime, date and place, a opinion, death occurr	and due to the car ed at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
	To the within 2 To the I complete	Me	29b. Signature and title of certifier	. ,	/ D	-	se number	29	d. Date signed (A	fonth, Day, Year)

D0061078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Stree RMN5W68.

31. Date filed (Month, Day, Year) SEP 3 0 2:005

State Registrar

		_	For State Registrar	State of Ma	aryland	•	artmen rtificat					Reg. No.	05	31759
	Physici	an	1. Decedent's Name (First, Middle, Last Walter Urba	-							2. Date of De Month Septem		Ž ^e ar 200	3. Time of Death 5 4:15 P M
	/Medio Examin	er	4a. Facility Name (If not institution, give 881 New London I	larbor				Pas	Location	a		4c. Cou	nty of Deat	undel
	Funeral Director		003-22-0201	X 7. Ag	e (In yrs. lasi 75	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da Aug. 1	1930	9. Birt	hplece (State or Foreign buntry) NY
-	Maryland 9-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	Arundel	10c. City, T	own or Lo	ocation	P	asad	ena				10d. Inside City Limits 1 ☐ Yes 2 ※ No
	with the e or 284 Lbe not	Director	10e. Street and Number 881 new London Ha	arhor			10f. Zip	Code	2112	2		10g. Citizen o	of What Co	ountry?
936	172 hours after death with the Maryland "neturel", or Items 23e or 28e-f show alloal Evaniner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedif Yes, spe			igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14. F E Spe	lace - Ame Black, Whit	nican Indian, e, etc. hite
Baltimore, Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Elementary/Secondary (0-12)				dent's Usu kind of wo DO NOT u	ork done d se retired	luring mos)		ing	16b. Kind of	Business/	·
land 2	should be filed voluded the Mental Hygie marked other imatic event, It	To Be Co	17. Father's Name (First, Middle, Last) Joseph Urbe	as					18. Moth	er's Name nnie	(First, Middle,	Maiden Sum i dl	ame)	
Mary	and and		19a. Informant's Name/Relationship (7 Elsie Joan Urbas	ype, Print) (SPOUS							al Route Number, Pasa			
ore,	000-		20a. Method of Disposition 1 ☐ Burial 2 ဩCremation 3 ☐	Removal from State	сет	e of Dispo	matory or o	other place		Sept	. 30	20c. Locatio		
Baltim	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral/Servic) Locen		Metr	o Cre	2. Name ar	nd Addres	s of Facili	ity	1	ngs Fu	neral	Maryland Home, P.A.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	dications that cause one calls on each li	the death.	Do not ent	ter the mod	de of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as			-	100	-700					
8760,	cate be executed by sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as		,								
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel de	ath 3	⊒Ectopic p ⊒ Other (s _i					T T	Date of del Month	ivery Day Year
ds, P	puires that n signed t		Part II. Other significant conditions of	ontributing to death t	out not resulti	ng in the u	inderlying (cause give	en in Part	l.		obacco use c Yes 2⊠No		the cause of death?
Division of Vital Records,		Completed by	Hyprokuria	, 							24a. Was autor perfo 1 ☐ Yes		prior to death?	utopsy findings available completion of cause of
Vita	ysicien: Th is certificate director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2□EF	R/Outpatie	nt 3 🗆 D	OA Othe	200		me 5 Resid		Other (Spe	cify)
ion of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		8b. Time o Injury		28c. Injun Work	at		28d. Describe I			
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	iury · At homic. (Specify)	e, farm, st	reet, factor	y, office			28f. Location (City or To		mber or Ri	ural Route Number,
	To the Hospitel within 24 hours and the Funerel completely filled	Medical		ysicien: To the best liner: On the basis o and manner st	of examination									
	To the H within 24 To the F	Me	29b. Signature and title of certifier	leb				D 2	362	4		Sept	ined (Mont	h. Day, Year) Z Uzi
	let 1		30. Name and address of person who of Basant Khande	completed cause of	death (Item 2	3a) (Type,	Print)	lwy '	Ste. 2	201	Glen B	urnie	cun,	21061
	Sta Regist		31. Date filed (Month, Day, Year) SEP 3 0 2005	32. Regist	rar's Signatur	Cons	and the same	,						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 29^{ay} Sept. Evelyn Measell Watkins 2005 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7530 Browns Bridge Howard Highland 8. Date of Birth (Month, Day, Year) Jan 28,1920 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** 1 □ M 2 X F 578-05-6090 85 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "netural", or Items 23a or 28e-f show If e Medical Exsolition and be notified at Director 1 ☐ Yes 2X No Highland Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7530 Browns Bridge 20777 death v USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Iter any injury or other traumatic event, Ite Madical Examinat once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerk Medical Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira D. Measell Rosalie Coffren 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alec E. Watkins, Husband 7530 Browns Bridge Highland, Maryland 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 09/29/05 Baltimore, Maryland 21. Signature of Funeral Service Licensus
Thomas Gregor ²² Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DERMATOMYOSITIS YEARL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No SMOKIES Completed been HUP FATENSON 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 49,2005 omplet use of death (Item 23a) (Type, Print) 5540 32, Registrar's Signature 31. Date filed (MC State Registrar

	· · · · · -		For State Registrar	State of Mary	land / Dep Ce	artmer ertifica	nt of Hotel	ealth ar Death			005	31761
	Physicia	an	1. Decedent's Name (First, Middle, Las Charles Dale Wi	nter					2. Date of Month		² 25, 200	3. Time of Death 05 6:14A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of D		40	. County of Deat	
			Upper Chesapeake M				Air	If Under 24	Hro a		Harford	
ı	Funeral Director		5. Social Security Number 6. Se 218–58–4609	XM 2□ F 7. Age (In	n yrs. last birthday Yrs.	Months			Min. 8. Date of (Month, Oct. 26	Day, Year 5 , 195	9. Birt 1 Mary	hplace (State or Foreign untry) rland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or I	ocation						10d. Inside City Limits
	e Mary 3a-f sh	ctor	Maryland Harford		Abingo	lon						1 ☐ Yes 2√CXNo
	a with th	Funeral Director	10e. Street and Number 309 Barclay Court				p Code 1009			-	itizen of What Co ${\sf S.A.}$	untry?
	ems 2	ınera	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13	. Was Dece	dent of His	spanic Origin	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be multiled at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		1 🗆 Yes		Specify:	,		0	hite
15-0	in 72 h	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Dec (Giv life.	edent's Usu e kind of w DO NOT i	ial Occupa ork done di ise retired)	tion u <i>ring</i> most o	f working	16b. k	Cind of Business/	industry
212	giene. er thar	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	Pair		,			Pa	inting	
and	be file	Be	17. Father's Name (First, Middle, Last)	1-					Name (First, Midd			
ž	should nd Mer marke imatic	To	William Winderweed 19a. Informant's Name/Relationship (7		19b. Mai	ling Addres	s (Street a		beth Mae or Rural Route Nur			Tip Code)
, Ma	and 2 saith ai n 27 is		Kelly Winter (Daug		12 0	aleta	Plac	ce, Ba	ltimore,			
Baltimore,	ages 1 nt of He t: if iten / or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	nemoval nom State	20b. Place of Disp cemetery, cri Bayview				Date pt 29 200		ocation - City or	Town, State Maryland
altir	mit. P partme portan y injury		21. Signature of superal 8 1 /lca 2 on:						ski Fune:	La contraction of the contractio		
m	\$ \$ E 5 8	(1756			1407	OTG F	aster	n Avenue	, ESS	ex, Mary	Tand ZIZZI
k			23a. Part1. Ther the disease, or comp shoot, or heart failure. List only of Immediate Cause (Final	one cause on each line.					rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a co	onsequence of):	A INC	mia.	·				
	Examiner	er	Sequentially list conditions, if any, leading to immediate	a. Cavalace Due to (or as a co	age ()	rrho	515					
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. nepat	itis							
8760,	ate be executed hysician and the burial-transit	Ical Ex	resulting in death) Last	Due to (or as a co	onsequence of):	2010	lenc	· Q .				
9	tificate ig phys as the			d. CCCCOV								
.O. Box	Attending Physician: The law requires that the death certificate be executed rideath. r death. ector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic p □ Other <i>(s</i>				-	23d. Date of deli Month	very Day Year
₾.	s that the property of details	by Ph	Part II. Other significant conditions co	11 1	ot resulting in the	underlying	cause give	n in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
ord	w require been sig should b	eted	acobetes nu	11/119					_	Yes 2	□No 3XPro	obably 4 Unknown
Records,	he law e has b ige 2 sl	Completed	COPD						pe	topsy rformed?	prior to death?	topsy findings available completion of cause of
ta	ian: T rtificate ctor, pa	Be Co	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check onl		1 Tes	2 No
of <	Physical this ce	얼	examiner? 1 □ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 K ER/Outpatie			- 4 IAUISII	ng Home 5 □ Re			city)
ion	nding I tth. :: After e funer	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injury	or M	28c. Injury Work 1 □ Y	at ? ′es 2.⊟No	28d. Describ	e now inju	ry occurred	
Division of Vital	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s Specify)	treet, factor	ry, office			(Street ar Fown, State		ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Phy	/sician: To the best of m iner: On the basis of exa and manner stated.	amination and/or i	nvestigatio	n, in my op	inion, death	occurred at the tim	e, date an	d place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	4		29	c. License	number		29d. Da	ite signed (Month	n, Day, Year)
	o		X Yamanwi	w m	D		002	922	2	Sept	embers	15,2005
	5		Kathryo L. Yam	ompleted cause of death	(Item 23a) (Type	Print)	م ر	hesai	peako I	Prive	Rol A	nivie (IM o
	Sta Registr		31. Date filed (Month, Day, Year) SFP 3 0 200	32 Registrar's	Signature						1	75, 2005 MD 21014
	riegisti	खा	SEP 3 V ZUI	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5 6 3							

DHMH 17 Rev 1/2001

Winter, Charles Dale

			State of Maryland / Department of Health and Mental State Registrar State Certificate of Death	tal Hygien	ZUUD 31/62
	Physicia		Restrice S. Ward	Date of Death	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death
	Funeral Director		214-30-5335 12 12 YIS.	Date of Birth Month, Day, Year	9. Birthplace (State or Foreign Gountry) Mary Land
	aryland ehow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 □ No
	th the Marrian	Funeral Director	Baltimore 100. Street and Number 107. Zip Code		Citizen of What Country?
	leath wii ns 23a c	eral	1439 Clairidge Road 21207 11. Marital Status 42. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify)	Yes or No-	J.S.A. 14. Race - American Indian,
36	be filed within 72 hours after death with the Maryland Hygiene. ed other then "natural; or items 23a or 28a-f ehow other then "natural; or items 20a or 20a-f ehow event, the Neulcal Exert car must be notified at	by Fun		n, etc.)	Black, White, etc. Specify: Black
21215-0036	C * 68	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/Industry
	filed within Hygiene. Ither then "	Comp	Elementary/Secondary (0-12) College (1-4or 5+) Graph Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First)	r J	laryland
Maryland	should be filed within and Mental Hygiene. s marked other then umatic event, the Mental County the Me	To Be			Midgett
Man	Ith ar 27 is 7 freu	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roll 19b. Mailing Address (Street and Number or Rural Roll 1439 Clairidge Rd		v or Town, Stand, Zip Code) imore, MD 2120
ore,	0 0		20a Method of Disposition J 20b. Place of Disposition (Name of Date	20c.	Location - City of Town, State
Baltimore,	permit. Pag Department Important: i any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Folity Cense	Funera	wings Mills, MD
8	8 2 2 8		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res	andalls	Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Interval Between Onset and Death
	/Medical Examiner		Due to (or as sconse vience of):		-/
—	ed sit	Examiner			
, , ,	be executed sician and burial-transit	I Exan	that initiated events ' c	<u> </u>	
68760	tificate be exigonable by the physician as the burial	ledical	d		
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
P.0.	uires that the de signed by the a Id be detached f			23e. Did tobacco	o use contribute to the cause of death?
ords,	w requires t been signe should be	ted by	1-11-6	1 🗌 Yes	2 No 3 Probably 4 □Unknown
Records,	ne taw re has be ge 2 sho	Completed	De la la la la la la la la la la la la la	24a. Was an autopsy performed?	
Vital		Be Co	25. Was case referred to medical again and a saminer?	1 Yes 2 Neck only one)	No 1 Yes 2 No
of	ਦੂ ਦੁ	n; To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home	5 X esidence Cescribe how inj	6 □Other (Specify) jury occurred
Division	Attending r death. sctor: After by the fune	Certification;	Accident S Pending (Month, Day Year) Injury Work? 2 Accident Accident Injury At home, farm, street, factory, office 28f. L	Location (Street a	and Number or Rural Route Number,
Div	ital or A irs after rei Dirac led in by			City or Town, Sta	ate)
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical		due to the cause(t the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To th Withir To th comp	Me	≥ 29b, Signature and title of certifier / / 29c. License number		Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ja	my 2005
	Sta	ate	e 31. Date filed (Month, Day, Year) 32/Aegistrar's Signature	onigs	אוום פוח נצוניתן
	Regist		CIBB A SOLE Kell Made Ma		

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 31763 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Williams Month **Physician** lerence September 2005 7:33 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** N/A500 block of North Decker Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number Sex 1 M 2□F yrs last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 219-88-0060 Rb. 16,197 Director man Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r then "natural", or Items 23a or 28a-f ehov tre Medical Examiner must be notified at 1 Xes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Tes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working SteeL Elementary/Secondary (0-12) College (1-4or 5+) Company rinder 12-11 NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H * Ie marked oth Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itsen 27 Is marked any injury or other traumatic events. Campbell regores 2 19a. Informant's Nam Relations ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - mother md, 21223 Williams Carey ma 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10 emeters CINIT 22. Name and Address of Facility, 1270 Pass 21. Signature uneral Service Licensee " march times at some . Back, and . 21229 or me disease, or complications that caused the death, heart failure. List only one cause on each line. Immediate ause (Final disease) condition resulting in death) **Physician** /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ed by the a 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of this certificate has al director, page 2 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 13€ Yes 2 No 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury Medical Certification; 1 Natural 5 Pending 1 TYes 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) (Street and Number or Rural Route Number, Homicide City or 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 21, 2005 29c. License number **OCME** 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year) SEP 3 0 2005 egistrar's Signature

		-	State of Maryland / Department / Department / Department / Department / Department / Department		-	005 31764
	Physicia /Medic	in.	Decedent's Name (First, Middle, Last) Catino Zappulla		2. Date of Death Month Day Sept 27, 2	3. Time of Death 3:00am м
	Examin	er	4a. Facility Name (If not institution, give street and number) 15504 Powe11 Lane	4b. City, Town, or Location of Death Bowie	Pr	ince Georges
	Funeral Director		5. Social Security Number 6. Sex 124 M 2 F 7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Year) March 9, 19	9. Birthplace (State or Foreign Country) 916 Italy
	Maryland -f ehow	tor	10a. State 10b. County 10c. City, Town or Loc	Bowie		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 28e st be noti	Funeral Director	10e. Street and Number 15504 Powell Lane	10f. Zip Code 20716	10g. Citize	en of What Country? USA
036	72 hours after death with the Maryland neture!', or items 23e or 28e-f ehow deal Examiner must be rodified at	þ	1 Never Married 2 X Married 1 Yes 2/7/No	As Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	s. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within noe. then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 16a. Deced (Give life. Life)	ent's Usual Occupation kind of work done during most of working O NOT use retired) Boat Builder	g 16b. Kind	d of Business/Industry Boat
and	d be filed vental Hygie ked other i c event, IL	To Be C	17. Father's Name (First, Middle, Last) Giuseppe Zapulla	18. Mother's Name	(First, Middle, Maiden S etta Sorbell	
Mary	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Address (Street and Number or Rural 4 Powell Lane Bowi	Route Number, City or	
Baltimore,	Page nent o ant: If ury or		20a Method of Disposition 20b. Place of Dispos		ite 20c. Loca	ation - City or Town, State Farmingdale NY
Balt	pernit. Pag Department Importent: I any injury o		10/10/2	Name and Address of Facility Charles L. Stevens Fun 1501 Fast Fort Ave Bal:	eral Home Inc. timore MD 212	30
×	Physician /Medical		23a. Part1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Porkins Constitution of the constit	Diseasewith	Demen.	Approximate Interval Between Onset and Death
3760,	ate be executed by sician and purial-transit in burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. J. L. L. L. Siv- Due to (or as a consequence of): Due to (or as a consequence of):	a of Prosto e Cancho Vasa	ulan Dis	Han Jeans
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med		Ectopic pregnancy Other (specify)		id. Date of delivery Month Day Year
Ф	w requires that been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
al Records,		Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
f Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes	26. Place of Death of 3 DOA Other: 4 Nursing Hom	(Check only one) e 5 Lesidence 6	□Other (Specify)
on of	nding Ph th. : After th e funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Accident	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Bd. Describe how injury	occurred
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	et, factory, office	3f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospite within 24 hours To the Funerel completely filled	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, ar estigation, in my opinion, death occurred	nd due to the cause(s) a d at the time, date and p	nd manner as stated. lace, and due to the cause(s)
)	To t withi To t	Σ	29b. Signature and yitle of certifier Kukh anong MD	29c. License number D 20108		signed (Month, Day, Year)
	19		30. Name and address of person who completed cause of death (Item 23a) (Type, Item Rakesh Arora MD 14300 Gallant Fox Lie		20715	
1961	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 3 0 2005 32. Registrar's Signature	arte		

				artment of Health and Me	ental Hygien	0005 21765
			1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. A	2005 31765
	Physicia	an			Month Da	**
	/Medic		Lurabelle D. Annis 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		12, 2005 3:35 P ^M
	Examin	er	Suburban Hospital			
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Bethesda If Under 1 Year If Under 24 Hrs.	8. Dete of Birth	Montgomery 9. Birthplace (State or Foreign
	Director		284-24-9927 1□M 25□F 94 Yrs.	Months Days Hours Min.	(Month, Day, Year June 5. 19	(Country)
g	>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			
arvia	oho a p	5				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	28a-f	Director	Maryland Montgomery Che	tvy Chase	100 C	itizen of What Country?
W.	3a or		8700 Jones Mill Road	20815	10g. 0	USA
death with the Maryland	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian,
affer o	e i		1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puèrto R 1 Yes 2 No Specify:	ican, etc.)	Black, White, etc.
5-UUSO	"natural", or items 23a or 28a-f ehow wolcal Examiner must be notified at	d by	3 X Wildowed 4 Divorced Year or Dates:			SpecifyWhite
	"nati	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given the complete of the complete o	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g 16b. l	Kind of Business/Industry
Mithin N	al Hygiene. i other than " vent, ice Ma		Elementary/Secondary (0-12) College (1-4or 5+)	acher		13
A L	ther nt,	Be C	17 Father's Name (First, Middle, Last)		(First, Middle, Maide	ducation n Sumame)
	fental l	o B	Arthur Davidson	Minnie M	Morris	
Mary	and Menta is marked reumatic ev			ling Address (Street and Number or Rural		
, IV	m 27 m 27 ner tr			N. 16th Street, An		
Saltimore	Department of Health and Menta Importent: if Item 27 is marked any injury or other treumatic evence.		INDIBUNAL 2 Cremation 3 Hermoval Itolii State	smatory or other place) Sept.	20c. L	ocation - City or Town, State
֓֞֝֜֞֜֝֞֜֜֝֜֝֟֜֜֜֝֟֜֜֟֜֟֝֜֟֜֟֜֟֜֟֜֜֟֝֜֟֜֟֜֟֜֟	rtent			Park Cemetery 2005		Petersburg, FL
ם E	Depa impo any i			Prancing Address Collins E OO University Blvd,	Tuneral Ho	me Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e			Approximate
P	hysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. — Arterial Thrombo Due to (or as a consequence of):	sis Lower Extremity		4 Days
E	xaminer		Sequentially list conditions.			
Ę.	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
5U,	and Il-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8/60 8/60	obysicien and the burial-transit	icai E				
Geath certificate	g phy as the	70				
XOD HE	attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	tha att	Physician/Me		Other (specify)		Month Day Year
	signed by tha a		Part II. Other significant conditions contributing to death but not resulting in the	underhing cause given in Part I	23e Did tohacco	use contribute to the cause of death?
ords, P	signe d be	d by	Dementia	anderlying cause given in acci.		X□No 3□ Probably 4 □Unknown
ecords	. O 75	leted			24a. Was an	24b. Were autopsy findings available
r g		Compl			autopsy performed?	prior to completion of cause of death?
		a)	25. Was case referred to medical	26. Place of Death	1 Yes 2 N	0 1 Yes 2 No
· ·	iis cei direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Othor	e 5 Residence	6 ☐Other (Specify)
_			27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at 21 Work?	8d. Describe how inju	ury occurred
VISION	death. ctor: A y the fu	cat	2 Accident investigation	M 1 Yes 2 No	04.1	1AL B. 1B
Division	in Direction	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	City or Town, Stat	nd Number or Rural Route Number, e)
U. Hospital or	24 hours afte		29a. Certifier 1 Cartifying Physicien: To the best of my knowledge, de.	ith occurred at the time, date and place, a	nd due to the cause(s	s) and manner as stated.
a d	n 24 h he Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date an	d place, and due to the cause(s)
Tothe	within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
١	0		· crume /	D37891	Sep	tember 12, 2005
1			30. Name and address of person who completed cause of death (Item 23a) (Typ. A. Rajvanshi, M.D. 121 Congressio	nal Lane, #400, Roc	kwillo M	D 20852
	Sta	ate			VATITE' W	D 20032
	Regist		31. Date filed (Month, Day, Year) SEP 1 6 2005 32 Registrar's Signature	DARL		

			State State Registrar AMEND #26PER PHY	of Maryland / De 9/16/05 CCHD DE	partment o	f Health and N	lental Hyg	giene 109. N2 0 0 5	31766
	Physici	an	1. Decedent's Name (First, Middle, Last)	, , , , , , , , , , , , , , , , , , , ,			2. Date of Dea	ith	3. Time of Death
	/Media	cal	Getty Viora Aker		0.50.5		Septemb	per 13,2005	
	Examir	er	4a. Facility Name (If not institution, give street and Pinetree Assisted Livi		Bryans	n, or Location of Death Road		4c. County of Dear	th
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. last birthda	ay) If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth	9 Bird	hplace (State or Foreign
	Director		231-22-8164 1□ M 2\(\frac{1}{2}\)F	80 Yrs	Months Da	ays Hours Min.	July	, Year 1925 Vi	rginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Mary P-f sh	tor	Maryland Charles	Indian	Head				Mar 2 No
	th the	Director	10e. Street and Number		10f. Zip Cod			10g. Citizen of What Co	ountry?
	s 23a		8 Fairmont Place			0640		U.S.A.	
(C)	d within 72 hours after deeth with the Maryland Jene. Ir than "natural", or items 23a or 28a-f show Ire Madical Exteringer rust be incilled at	Funeral	1 Never Married 2 Married 1 Ye	s 2 No		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e, etc.
003	ural, c	d by	3 X Widowed 4 □ Divorced If Yes, Year o	r Dates:	1 ☐ Yes 2X☐	No Specify:		Specify: Wh	
15-(n 72 h	Completed	15. Decedent's Education (Specify only highest grade complete	16a. De (G	cedent's Usual Od ive kind of work do DO NOT use re	ecupation one during most of work stired)	ing	16b. Kind of Business	Industry
212	within jiene r than "	omp	Elementary/Secondary (0-12) College	Bake			1	Board of Ed	ucation
nd	를 찾을 받	Bec	17. Father's Name (First, Middle, Last) Lewis S. Sisk					Maiden Sumame)	
ryla	2 should be finand Mental his marked of reumatic ever	10	19a. Informant's Name/Relationship (Type, Print)	105.14	-:Ba- 6.dd /CA	Alice E.			7-0-4-1
Maryland 21215-0036	s 1 and 2 should of Health and Men item 27 is marke other treumatic					lace, Indi			cip Code)
Baltimore,	of Head		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal fro	20b. Place of Dis	sposition (Name of crematory or other	f place) Sept. 1.	Bate 2005	20c. Location - City or	Town, State
ţ	t. Pag rtment rtent: njury o		* 4 □ Donation 5 □ Other (Specify)	Trinity		1 Gardens		Waldorf, M	
Ba	permit. Pages 1 a Department of Hei importent: if item any injury or othe		21. Signature of Funeral Service Licensee	M00668	Williams 4270 Haw	dress of Facility Funeral Horthorne Rd.	ome, P.A , Indian	Head, Md.	20640
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ALZHE	IME	2'5			Onset and Death
	/Medical Examiner		Due	to (or as a consequence of):					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):					
	e be executed rsicien end e burial-transit	Examiner	that initiated events C.	to (or as a consequence of);					
8760,	sicien buria			to (or as a consequence or).					
9	ifficate g phys as the	ledic	d						
Вох	eath certific attending pl for use as t	an/N		outcome of pregnancy e birth 2 🗍 Fetal death	3 □Ectopic pregna	ancy		23d. Date of del Month	ivery Day Year
0.	t the dea by the a tached for	Physician/Medical	1 Yes No 9 Unknown 9 Ur		5 ☐ Other (specif)	/)		World	Day Tour
σ.	The law requires that the death certificate be executed tense been signed by the attending physicien end tage 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	e underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ords	w require been sig should b	ted t					1 🗀 Y	es 2 □No 3 □ Pr	obably 4 Dhknown
Records,	e law r has be	Completed					24a. Was a autops	sy prior to o	topsy findings available completion of cause of
alF		e Co	25. Was case referred to medical			00 01(0		≥ Pro 1 □ Yes	2 No
Vital	Physicien: this certific ral director.	o B	examiner?	☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA	26. Place of Deat Other: 4 \(\sum \) Nursing Ho	(4) (4)	ence 6 X Other (Spec	ASSISTANT
n of		on: T	27. Manner of Death 28a. Da	te of Injury onth, Day Year) 28b. Time Injur	e of 28c. I	the state of the s	-	ow injury occurred	"HIVING
Division	uttendi death. ctor: A y the fu	Icati	2 Cident investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm,		1 ☐ Yes 2 ☐ No	29f Location /S	treet and Number or Ru	ural Pauta Alumba
<u>></u>	al or Attended state of the color:	Certification;	4 Homicide determined bu	ilding, etc. (Specify)	street, ractory, on	ice	City or Town		rai Houle Number,
	To the Hospital or Attending within 24 hrurs after death. To the Funeral Director: After completely litted in by the fune	edical (29a. Certifier (Check only one) Certifying Physicien: To 2 Medical Examiner: On the and m	the best of my knowledge, de basis of examination and/or anner stated.	eath occurred at the investigation, in r	e time, date and place, ny opinion, death occur	and due to the cred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier		29c. Lic	cense number	2	9d. Date signed (Monti	n, Day, Year)
^			1 K March	average of death (the control of the	17	2555		91141	45
1	B 25		30. Name and address of person who completed c	ause of death (item 23a) (Typ	3 L	oflate		of co	0646
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 6 2005	Registrar's Signature	Societies				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year CATHERINE L. ABBOTT Sept 2005 12:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis HealthCare -The Pines Easton Talbot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG 2 1914 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2□¥F MARYLAND Director 212-16-1005 91 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at 1 Yes 2 No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Catherine Abbott Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 XWidowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD LEONARD LOUISE WILLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health al Important: If itam 27 is any injury or other trat <u>000.9.</u> DIANA JONES/NIECE PO BOX 251 ST. MICHAELS, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ACremation 3 ☐ Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 9/13/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 M. Ostavusti Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final estive heart failure **Physician** disease or condition resulting in death) wasters /Medical **Examiner** heroschoosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events attending physiclan and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellans 3 Probably 1 ☐ Yes 2 ☐ No Completed brovescular monficiency 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the within 24 hours after deatl To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9.12.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CROWLEY MO GIO DUTCHMANS 31. Date filed (Month, Day, Year) 32. Regarar's Signature State SEP 13 Registrar

			For State Registrar	State of	of Maryla	-	artment of H		d Mental Hy	giene Reg. No20	05 31	768
	Physici		Decedent's Name (First, Middle James]		kins				2. Date of De. Month	ath Day	Year 3. Time o	
	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location of D		aber 15,		0 A ^M
	F		Laurel Region: 5. Social Security Number	al Hospita 6. Sex	7. Age (In vrs	. last birthday)	Laure1	If Under 24	Hrs. 8 Date of Bid	Princ	ce Georges 9. Birthplace (State	
	Funeral Director		217-30-0745	1 ∑ M 2□F	69	Yrs.	Months Days		March March	2, 1936	Tennessee	2 2
	ow III		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation	-			10d. Inside C	City Limits
	e Many 3e-f sh	ctor	Maryland Howar	d	Wo	odbine					1 ☐ Yes	2 ∑ No
	3a or 20	Il Director	10e. Street and Number 2994 Florenc	e Road			10f. Zip Code 2179	7		10g. Citizen of V		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importents: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any fujury or other treumatic event, the Medical Examinar must be notified at an ance.	by Funeral	11. Marital Status 1 □ Never Married 2 X Marri 3 □ Widowed 4 □ Divorced	Armed Fo	2 TXNo		Was Decedent of Hi If Yes, specify Cuba	spanic Origin n, Mexican, P Specify:	? (Specify Yes or No- ruerto Rican, etc.)	- 14. Rad Blad Specifi	ce - American Indian, ck, White, etc.	
9	2 hour	ted k	15. Deceden	t's Education	vales:	16a. Dece	dent's Usual Occupa	ation		16b. Kind of B	White usiness/Industry	
21215-0036	within 7 ne. han "r	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	luring most of)	working			
2	Hygie other t	Be Co	10th 17. Father's Name (First, Middle,	Last)		Ca	rpenter	18. Mother's	Name (First, Middle,		ruction	
ylan	Menta Menta arked atic ev	To B	Manuel	Atkins	_			Alp	ha Johnsor	n		
Maryland	d2shuth and th and the m treum		19a. Informant's Name/Relations			222			r Rural Route Numbe			
Baltimore,	ges 1 an of Heal If item 2 or other		Robbie J. Atki 20a. Method of Disposition 1 Burial 2 Cremation		20b.	2994 Place of Dispo cometery, crea	FLOrence esition (Name of matory or other place	Road	Woodbine Date		and 21797 City or Town, State	
<u>=</u>	iit. Pag artment ortent: injury		* 4 ☐ Donation 5 ☐ Other (S 21. Signat, re of Funeral Service	pecify)	Po		prings Ce 2. Name and Addres		9/18/05	Mt. Air	ry, Marylan	ıd
Ba	Depermine Depermine Important in policies		Novert L	. Wille	ams) 0	lin L. Mo	leswor	th P.A., E Damascu			2-011
To the last	Physician /Medical	8	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Left	each line.	th. Do not ent	er the mode of dying Basal Gar	g, such as car	diac or respiratory ar	rest,	Approximat Interval Bet Onset and I	te tween
	Examiner	<u>.</u>	Sequentially list conditions,	Mel:	ignant	Hypert	ension					
	uted d ansit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		•		betes Mel	litus				
8760,	icate be executed physiclen and s the burial-transit	dical Exe	resulting in death) Last		oras a conse pirator		ure					
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ointh 2 ☐ Feta nant at time of	al death 3□	Ectopic pregnancy Other (specify)				te of delivery inth Day	Year
<u>s</u> ,	es that igned b	by Pt	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use cont	ribute to the cause of d	leath?
Record	w require been si should t	eted	Bilateral External Seps		umonia				_ 1 U Y	es 2□No	3 Probably 4X1	Jnknown
	The law ete has b page 2 s	Completed	Renal Insuffic						24a. Wasa autop perfor	rngd?	Were autopsy findings a prior to completion of ca death? 1 □ Yes 2 □ No	available ause of
Viital	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hacnital:			othe	-	Death Check on or			
Division of	ding Ph h. After th funeral	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date (Mon		28b. Time of Injury	28c. Injury Work	at	ng Home 5 ☐ Resid 28d. Describe h			
Divis	tel or Attenrs efter deat sel Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Route Numi	ber,
	To the Hospitel within 24 hours of the Funerel completely filled	edical	29a. Certifier 1 ☑ Certifyin (Check only one)	Examiner: On the b	best of my knoasis of examination	owledge, death ation and/or inv	occurred at the time vestigation, in my op	e, date and pl inion, death o	ace, and due to the coccurred at the time, o	cause(s) and ma date and place, a	inner as stated. and due to the cause(s))
	To ti withiu To th comp	Me	29b. Signature and title of certifier	/ //	. 2 1 1	D	29c. License	number	2	29d. Date signed	d (Month, Day, Year)	
	<		30 Name and Silver		12 M		D2120	00		Septemb	er 15, 200	5
_	ワ		30. Name and address of person S. R. Udap					Gree	enbelt, Ma	ryland	20770	
	Sta Registr	100	31. Date filed (Month, Day, Year)	00.0	egistrar's Sign	- 4	•			7 - 27 - 12		

		1 - For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>		ınd Mei		iene (5 3	1769
Dhamiai		1. Decedent's Name (First, Middle, Las	st)				2.	Date of Death Month		Year 3.	Time of Death
Physici /Medi		John Elmer	Adkins, Sr.				Se	eptembe		_	:45 P M
Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	f Death		4c. County of	of Death	
		Northampton Manor 5. Social Security Number 6. S		last hirthday)	Frede:		4 Hrs. lo	Date of Righ		derick	
Funeral Director			M 2□F 81	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, une 28	Year) 1924	Gountry) Maryla	(State or Foreign
ס		Usual Residence of Decedent							, ->- 1	rary ra	iid
arylar show	-	10a. State 10b. County		y, Town or Lo							nside City Limits
the M	Director	Maryland Frederi	ick	Jefi	ferson						☐Yes 2⊠No
with	급	3823 Roundtree F	Road		10f. Zip Code	755		10	ng. Citizen of W	State	
In yearly 2 12 12 15 15 15 2 2 5 5 5 5 5 5 5 5 5	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		in? (Specify	y Yes or No-		- American In	
or Ita		1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Specify:	, Puerto Ric	an, etc.)		, White, etc.	i to
ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates: WWII						Specify:	WII	ite
"nat	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most	of working	1	16b. Kind of Bus	siness/Industr	у
iene.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Farm		,			Agricu	1+	
a filed I Hyg other	a l	17. Father's Name (First, Middle, Last))	, , , ,		18. Mother	r's Name <i>(F</i>	irst, Middle, M	faiden Sumame		
uld be Wenta Menta Irked	To B	Keefer Earl Adki	ins			Lo	ottie	Routza	hn		
and lame		19a. Informant's Name/Relationship (** *	19b. Mailir	ng Address (Street a	an <i>d Nu</i> mber	r or Rural R	oute Number,	City or Town, S	State, Zip Cod	(e)
Tey, Middly grafted Z. 12.10000000000000000000000000000000000		Bonnie J. Pryor /			Emmitsbur				Maryla		
in to fr		20a. Method of Disposition 1 XBurial 2 Cremation 3 C	Juanioval Iloni State		osition (Name of matory or other place	100	Date epteml	ber	20c. Location - 0	•	
it. Pa intmer intmot njury		*4 □Donation 5 □ Other (Specifical Licer			Mem Gard 2. Name and Address						•
permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		1200 Z	-		521 Opossi		Stat	iffer F	uneral	Homes,	P.A.
Physician		23a. Part1. Enter the disease, or com shock, or heart failer. List only	plications that caused the death one cause on each line.					27 ha			proximate
1 Hysician		Immediate Cause (Final		V	1 -			()		Inte	rval Between set and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a consequ	euence of):	1 -	er L		()	resine	Inte	rval Between
/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequence)	euence of):	1 -			()		Inte	rval Between
Examiner	iner	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. Due to (or as a consequence of the consequence o		1 -			()		Inte	rval Between
Examiner	xaminer	disease or condition resulting in death)	b. Due to (or as a consequence.	uence of):	1 -			()		Inte	rval Between
Examiner	al Examiner	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	uence of):	1 -			()		Inte	rval Between
Examiner		disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence.	uence of):	1 -			()		Inte	rval Between
Examiner		disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to (or as a consequence of pregnation	uence of): uence of):	enti			()	pessine	Inte	rval Between
Examiner		disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy I death 3	1 -			()	pessine	Inte Ons	rval Between
Examiner		disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy il death 3 [leath 5 [Ectopic pregnancy	e i		Prog	23d. Date Mon	of delivery	rval Between et and Death
Examiner	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy il death 3 [leath 5 [Ectopic pregnancy	e i		23e. Did toba	23d. Date Moni	of delivery	Year wise of death?
Examiner	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy il death 3 [leath 5 [Ectopic pregnancy	e i		23e. Did toba	23d. Date Montage accourse contriles 2 \(\text{No} \)	of delivery	rval Between et and Death
Examiner	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy il death 3 [leath 5 [Ectopic pregnancy	e i		23e. Did toba	23d. Date Montage accourse contril s 2 \(\text{No} \)	of delivery th Day bute to the car B Probably	Year wise of death?
Examiner	Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy il death 3 [leath 5 [Ectopic pregnancy	en in Part I.	with	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2	23d. Date Moniacco use contril s 2 \(\text{No} \) \(\text{24b. W} \)	of delivery th Day	Year Year 4 Gunknown indings available ion of cause of
Examiner	Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Contributing to death but not rest	uence of): uence of): ancy I death 3 [eath 5 [Ectopic pregnancy Other (specify)	en in Part I.	of Death (C	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2' theck only one	23d. Date Moniacco use contriles 2 No 3	of delivery the Day bute to the car autopsy finar to complet satt?	Year Year 4 Gunknown indings available ion of cause of
yalcian: The law requires that the death certificate be executed by social soci	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence. Due to (or as a consequence. d	uence of): uence of): ancy il death 3 [leath 5 [ulting in the u	□Ectopic pregnancy □ Other (specify) Int 3□ DOA Other	en in Part I. 26. Place o	ot Death (C	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2' theck only one 5 Resider	23d. Date Moniacco use contril s 2 \(\text{No} \) \(\text{24b. W} \)	of delivery th Day bute to the car B Probably ere autopsy fi ior to complet eath? (Specify)	Year Year 4 Gunknown indings available ion of cause of
yalcian: The law requires that the death certificate be executed to so cartificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): ancy I death 3 [eath 5 [ulting in the u	□Ectopic pregnancy □Other (specify) □ Int 3□ DOA f 28c. Injury Work	en in Part I. 26. Place o	ot Death (Crising Home	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2' theck only one 5 Resider	23d. Date Moni	of delivery th Day bute to the car B Probably ere autopsy fi ior to complet eath? (Specify)	Year Year 4 Gunknown indings available ion of cause of
yalcian: The law requires that the death certificate be executed by social soci	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): uence of): ancy I death 3 [eath 5 [ulting in the u ER/Outpatier 28b. Time o Injury	Dectopic pregnancy Other (specify) Int 3 DOA other at 3 DOA other dectopic pregnancy Other (specify) and 3 DOA other M 1 DOA	26. Place of attractions of the state of the	ot Death (C sing Home 28d	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes theck only one 5 Resider Describe how	23d. Date Moniacco use contril s 2 \(\text{No} \) \(\text{Solution} \) \(\text{No} \) \(\text{1} \) \(\text{No} \) \(\te	of delivery th Day oute to the car B Probably ere autopsy fi ior to complet eath? (Specify) d	Year Year 4 Onknown indings available ion of cause of
yalcian: The law requires that the death certificate be executed to so cartificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence. C. Due to (or as a consequence. 23c. If yes, outcome of pregnance. 1	uence of): uence of): uence of): uence of): ancy il death 3 [leath 5 [ulting in the u ER/Outpatier 28b. Time of Injury ome, farm, str	□Ectopic pregnancy □Other (specify) □nderlying cause give nt 3□DOA f 28c. Injury Work M 1□N reet, factory, office	26. Place of art 1.	ot Death (Craing Home 28d	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2' theck only one 5 Resider Describe how	23d. Date Monitorial State) 23d. Date Monitorial State Stat	of delivery th Day bute to the car B Probably for autopsy finer to complete high Probably for autopsy finer to complete for a	Year Year use of death? 4 Onknown indings available ion of cause of No
yalcian: The law requires that the death certificate be executed to so cartificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): uence of): uence of): ancy il death 3 [leath 5 [ulting in the u ER/Outpatier 28b. Time of Injury owne, farm, str	Detectopic pregnancy Other (specify) Int 3 DOA other M 1 DOA reet, factory, office	26. Place of arr. 4 livers at the control of the co	of Death (Cosing Home 28d	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2: Check only one 5 Resider Describe how	23d. Date Moni acco use contril s 2 \(\text{No} \) 24b. W A control of the con	of delivery th Day oute to the car B Probably ere autopsy fi ior to complet suth? (Specify) d or or Rural Rou	Year Year use of death? 4 Dinknown indings available ion of cause of No
yalcian: The law requires that the death certificate be executed to so cartificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	ertification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): uence of): uence of): ancy il death 3 [leath 5 [ulting in the u ER/Outpatier 28b. Time of Injury owne, farm, str	Detectopic pregnancy Other (specify) Int 3 DOA other M 1 DOA reet, factory, office	26. Place of art 1.	of Death (Cosing Home 28d	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 25 Resider 5 Resider Location (Street, City or Town, due to the cau at the time, dat	23d. Date Moni acco use contril s 2 \(\text{No} \) 24b. W A control of the con	of delivery th Day oute to the car and Probably ere autopsy fiver to complete the complete the complete the care. If (Specify) description of the care autopsy fiver to complete the care autopsy fiver the care autopsy fiver to complete the care autopsy fiver to complete the care autopsy fiver to complete the care autopsy fiver the care autopsy fiver to complete the care autopsy fiver to complete the care autopsy fiver to complete the care autopsy fiver the care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autopsy fiver to care autops	Year Year use of death? 4 Onknown indings available ion of cause of No
taw requires that the death certificate be executed to some signed by the attending physician and should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit to should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	uence of): uence of): uence of): uence of): ancy il death 3 [leath 5 [ulting in the u ER/Outpatier 28b. Time of Injury owne, farm, str	DEctopic pregnancy Other (specify) Inderlying cause give Int 3 DOA	26. Place of art 1. 26. Place of art 2. Yes 2 \(\subseteq \) N The date and pinion, death	of Death (C) sing Home 28d.	23e. Did toba 1	23d. Date Month acco use contril as 2 \(\text{No} \) No 3 (4b. W prode 1) (4c. Architecture) No 1 (4c	of delivery th Day bute to the car B Probably ere autopsy fi ior to complet eath? (Specify) d r or Rural Rou mer as stated, d due to the car (Month, Day,	Year Year Year 4 Onknown Indings available ion of cause of No Inte Number, cause(s)
yalcian: The law requires that the death certificate be executed to so cartificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnance. 1	uence of): uence of): uence of): uence of): uence of): ancy ideath 3 [eath 5 [ulting in the uence of): ER/Outpatier 28b. Time of Injury ome, farm, str y) owledge, deatt tition and/or in	DEctopic pregnancy Other (specify) Inderlying cause give Int 3 DOA	26. Place of art 1. 26. Place of art 2. Yes 2 \(\subseteq \) N The date and pinion, death	of Death (C) sing Home 28d.	23e. Did toba 1	23d. Date Month acco use contril as 2 \(\text{No} \) No 3 (4b. W prode 1) (4c. Architecture) No 1 (4c	of delivery th Day bute to the car B Probably ere autopsy fi ior to complet eath? (Specify) d r or Rural Rou mer as stated, d due to the car (Month, Day,	Year Year Year 4 Onknown Indings available ion of cause of No Inte Number, cause(s)
yalcian: The law requires that the death certificate be executed to so cartificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnance. 1	uence of): uence of): uence of): uence of): ulting in the u ulting in the u ER/Outpatier 28b. Time of Injury ome, farm, str y) weledge, deatt tition and/or in	DEctopic pregnancy Other (specify) Inderlying cause give Int 3 DOA	26. Place of art 1. 26. Place of art 2. Yes 2 \(\subseteq \) N The date and pinion, death	of Death (C) sing Home 28d.	23e. Did toba 1	23d. Date Month acco use contril as 2 \(\text{No} \) No 3 (4b. W prode 1) (4c. Architecture) No 1 (4c	of delivery th Day bute to the car B Probably ere autopsy fi ior to complet eath? (Specify) d r or Rural Rou mer as stated, d due to the car (Month, Day,	Year Year use of death? 4 Onknown indings available ion of cause of No

DHMH 17 Rev 1/2001

Ouincy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 005

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Day **Physician** CC 22 AM ler 03 2005 Man /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | 9. Birthplace (State or Foreign Country) | 1. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗙 F 60 239-68-8546 December North Carolina Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ehow The Medical Examiner must be notified at 1X Yes 2 □ No Potomac Maryland Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or 20854 United States 7736 Scotland Drive deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Nes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then Homemaker Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked oth jury or other traumatic even Lucille Munford Zana Hughes Moore William 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7736 Scotland Drive; Potomac, Maryland 20854 Aldin Bryant (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery | Sept. 17, Germantown, Maryland 21 gnatura of Funeral Service Licenses R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N. W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner ecks win Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Dinbetes and Due to (or as a consequence of): Box 68760 physiclen Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ò Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA SU 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury efter death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide To the Hospital within 24 hours e To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eptenber 3,2005 30. Name and address of person who comp cause of death (Item 23a) (Type, Print) 9901 medical center am11. ma ROCKUILLE, Mr 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 1 6 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SEP Year Physician JOHN ANTHONY BONNER 13 2005 11:38 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 27, 2005 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Director Maryland None Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits ns 23a or 28e-f ehow must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Alexandria Fairfax County Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6507 John Thomas Drive 22315 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: Specify: Specify: Caucasian 3 Widowed 4 Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ermit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Inportent: If Item 27 is marked other then "in yi hijury or other treumetic event, Ite Mustice. Elementary/Secondary (0-12) College (1-4or 5+) None None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Rvan Sloan Bonner Jaime M. Fantaci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6507 John Thomas Drive Alexandria, VA 22315 Ryan Sloan Bonner - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any Injury or Sept. 28, 2005 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 22. Name and Address of Facility Jefferson Funeral Chapel 21. Signature of Funeral Service License 5755 Castlewellan Dr. Alexandria, VA 22315 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician EXTREME PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the. IF FEMALE esn 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Year Day Pregnant at time of death 5 Other (specify) P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 2 No 1 XYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No P 1 Monation 2 ☐ ER/Outpation 3 ☐ DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 2 D0044634 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 JEFFREY R. GREENWALD CAPT MC USN State Registrar

		riease		nuland / Dan			•	•	
		1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	rtificate of			2005	31773
Dhysisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		Edward Lee B					September	18 0501	250441 "
Examin	er	4a. Facility Name (If not institution, give	~ , 1		4b. City, Town,	or Location of Death		4c. County of Dea	2 DT
Funeral		Memorial H 5. Social Security Number 6. Se	OSPITOU 7. Ag	e (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day, Y		rthplece (State or Foreign
Director		217-42-7403	≾ M 2□F	62 Yrs.	Months Days	Hours Min.	August 5	1943	Maryland
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary Nany	tor	MD Dorches	ter		Camb	oridge			1 ☐ Yes 2 🕱 No
10 8 2 2 2	Director	10e. Street and Number			10f. Zip Code		100	J. Citizen of What C	ountry?
253 with W	rail	3000 Old Route		5in 11.0	Mac Bassassas	21613		USA 14. Race - Am	ariaan Indian
6 July 23	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕱	No 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	o Rican, etc.)	Black, Wh	
LOCK BRUTH BRUTH BLC More, Maryland 21215-0036 All Maryland 21215-0036 Maryland 21215-0036 Maryland to 6 Health and Mental Hygiene. If item 27 is marked other than "natural", or items 238 or 286-1 show or other treumatic event, the Madical Examiner must be notilised as	by	3 Widowed 4 Divorced	1 Yes 2 Xi If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
72 h 72 h 72 h	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king 16	6b. Kind of Busines	s/Industry
within siene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5	5+)	vaterman	50/		seafo	ood
be filed that Hygie of other event, in	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma		
Rel B Raryland 212: 2 should be filed within and Mental Hygiene. is marked other than event, the Manalic eve	To	James W. Bramble					Morris		
Baltimore, Maryland permit. Pages 1 and 2 should be fill Department of Health and Mental Himportent: If them 27 is marked oth any injury or other treumatic even once.	1 3	19a. Informant's Name/Relationship (1 Cheryl Bramble	туре, Print) Wif		•		ral Route Number, (,	_
Cre, No 1 and 1 Health tem 27 other tr		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of	ite 50, Ca	mbridge, Date 20	MD 2161. Oc. Location - City o	
Baltimore, M. Baltimore, M. Permit. Pages 1 and 2 Department of Health amportent: If them 27 is any injury or other tre once.		1 X Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Specify					/21/05	ambridæ.	MD .
Batti permit. Departitimports any inju		21. Signature of Funeral Service Licen	see				omas Fune		
/// m goraa		for willow					mbridge,		
		23a. Party. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	200		er the mode of dy	ing, such as cardiac	or respiratory arres	ι,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	a consequence of):					3 days
Examiner		Sequentially list conditions	, Pre	umonia	-				7 dogs
sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
760, be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
760, te be ex ysician a	calE	l	d						
difficat ng physias th		IF FEMALE:						T	
P.O. Box 68' nat the death certificat d by the attending phy letached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	су		23d. Date of de Month	elivery Day Year
o. In the de	ysic	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death 5 L	Other (specify)				·
Records, P.O. Box 687. The law requires that the death certificate I ate has been signed by the attending physicage 2 should be detached for use as the long.	by Pr	Part II. Other significant conditions of			nderlying cause g	iven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ords	ted t	Acute divert Fibrothora	-1culities	1 D	abete	\$	1 🖳 Yes	2 □ No 3 □ F	Probably 4 Unknown
(1) a a (2)	Completed		x lett	Co-	-gestive	boot tale	autopsy	prior to	utopsy findings available completion of cause of
Vital Rec sicien: The lav certificate has		COPD		•			performe 1 ☐ Yes 2 ☐	9√No 1 □ Ye	s 2ENO
of Vita Physicien: rthis certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [Inpatie	ent 2 ER/Outpatie	nt 3 DOA Ot	thon	th (Check only one) ome 5 Residen		acifu)
on of ding Phys n. After this funeral di	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		f 28c. Iniu		28d. Describe how		rony)
Division of Vital Records, tor Attending Physicien: The law requires that after cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be on the page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be			M 1]Yes 2 □No			
OIVI or Att after d Direct in by	ertifi	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Spitel Tours of Indied		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, deat	h occurred at the t	time, date and place	, and due to the cau	se(s) and manner a	s stated.
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha	edicai	(Check only 2 Medical Exen	niner: On the basis of and manner sta	l examination and/or in	vestigation, in my	opinion, death occu	rred at the time, date	e and place, and du	e to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	H MT			1 4 7 4 9	290	I. Date signed (Mon	_
		20 Name and address of access to	completed aguas of	Joseph (Ital 225) (T.		7/77		2/18/10)5
		30. Name and address of person who experts Whites				ne, Easto	n, MD 21	601	
Sta		31. Date filed (Month, Day, Year) SEP 2 0		ar's Signature	haut .				
Regist	aľ	OF! ~		TOUR SUP I	ALL AND THE STATE OF THE STATE				

DHMH 17 Rev 1/2001

		í	For State Registrar	State of	f Marylan	d / Depa	artment rtificate	of H	ealth a	and Me	ental Hyg	ierze eg. No.	05	31774
	D 1		1. Decedent's Name (First, Middle,	Last)							2. Date of Deat Month	th Day	Year	3. Time of Death
	Physici /Medio	al	Ruby Powley								Sept.	15	2005	8:30 p. ^M
}	Examin		4a. Facility Name (If not institution,						Location o	of Death			unty of Death	
			Mallard Bay				If Under 1		idge	24 1400	0.5		Dorche	
	Funeral Director		5. Social Security Number 213–22–9345	6. Sex 1 ☐ M 2 🜠 F	7. Age (In yrs. 97	last birthday) Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, Dec. 8,	Year) 1907		place (State or Foreign ntry) yland
	p		Usual Residence of Decedent		10a Cib	v. Town or Lo								Od. Inside City Limits
C	Aaryla f shov	ō	10a. State 10b. County MD Dorch	nester	100.01	y, TOWN OF LC	Camb	hrid	lae					1 XYes 2 □ No
5	1286-	Director	10e. Street and Number				10f. Zip (.,,,,		1	0g. Citizer	of What Cour	ntry?
2	72 hours after death with the Maryland natural; or ttems 23a or 28e-f show deat Examinat must be notified at	raiD	1631 Race St.						2161				USA	
4	er de tems	Funeral	11. Marital Status	Armed Fo	ident Ever in U.	.S. 13.	Was Decede If Yes, specif	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)	14.	Race - Americ Black, White,	
920	urs aft ai', or	b	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or D	e ates:		1 🗆 Yes 2	⊠ No	Specify:			Sp	ecify: Wh	ite
2-0	72 ho	ted	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual kind of work	Occupa	ation during most	t of workin	a	16b. Kind	of Business/In	dustry
121	filed within Hygiene. Hygiene. Ither than "ant, in a Mer	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	no not use homer	e retired,)			07.	n home	
2	filed v Hygie Ather ti		10 17. Father's Name (First, Middle, L	ast)			TOTIE	liane		r's Name	(First, Middle, I			
lan(id be lental ked o	To Be	Thomas A. I								Jones			
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene with the marked other than "natural; or thems 23a or 28e-f show item 27 is marked other than "natural; or thems 23a or 28e-f show other treumatic event. The Medical Examinar must be notified at		19a. Informant's Name/Relationsh			19b. Maili	ng Address ((Street a	and Numbe	er or Rural	Route Number	, City or To	own, State, Zip	Code)
	i and lealth em 27 ther tr		Morris W. Blood 20a. Method of Disposition	dsworth	son	1309 Place of Dispo			, Can		e, MD	2161 20c. Locat	ion - City or To	own. State
Baltimore,			1 Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		State	cheste cheste	matory or oth	her place		k 9/			ridge,	
äţţ	コモモデ		21. Signature If Juneral Service		501						omas Fu			
ä	Depar Impo any ir once.		> ifhurt	em		7	00 Loc	cust	st.,	Caml	oridge,	MD	21613	
н			23a. Part1 Enter the disease, or o shock, or heart failure. List o	only one cause on e	ach line.							est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ar	Jeriusc or as a conseq	lent:	Cordi	overc	ulr	dis	ease			
	Examiner		O		new No									
	sit ad	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence of):								
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):								
760,	re be e ysician e buria	caiE		d										
89	ng ph as th		IF FEMALE:											
Вох	death certificat e attending phy id for use as th	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna irth 2 Feta	death 3	Ectopic pre					23d	. Date of delive Month	ery Day Year
	0 0 0	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno	ant at time of d	leath 5L	Other (spe	спу)				,		
٦,	The law requires that the ate has been signed by the page 2 should be detache	by Pt	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying ca	iuse give	en in Part I.		23e. Did tol	oacco use	contribute to th	ne cause of death?
ords	w raquire been sig should b					· · · · · · · · · · · · · · · · · · ·					1 🗆 Ye	s 2 🖭	6 3□Prob	pably 4 □Unknown
Records,	e law r has be ge 2 sh	Completed									24a. Was a autops perform	V	4b. Were auto prior to co- death?	psy findings available mpletion of cause of
al F	ilcien: The la certificate ha rector, page ?										1 ☐ Yes	2/ No		20 No
of Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2	ED/Outpation	a 🗆 DO	Othe	35	/	(Check only on e 5 ☐ Reside		Othor (Consider	
	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o		Bc. Injury Work			Bd. Describe ho			y)
ion	anding I ath. or: After ne funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	n, Day 1 Gar)	Hijury	М		Yes 2 🗆 !	No				
Division	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 286, Place	of Injury - At hong, etc. (Specif	ome, farm, st fy)	reet, factory,	office		2	8f. Location (St City or Town		lumber or Rura	I Route Number,
	spitei ours a nerel I		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, deat	h occurred a	ıt the tim	ne, date an	d place, ar	nd due to the ca	ause(s) an	d manner as s	tated.
	To the Hospitei within 24 hours a To the Funeral Completely filled	edical	one)	xaminer: On the band man	asis of examina ner stated.	ition and/or in				th occurre				
	To T To 1	M	29b. Signature and title of certifier	guer 1	90				number	.4			igned (Month,	
,			30. Name and address of person v	who conveleted caus	e of death (Iten	n 23a) (Tvne	Print)	24	112	-1		/ .	1-03	
			NOMAN THAT			RORA	58	CI	ACT BR	2100	e M	0	2161	3
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005	gistrar's Signa	ature	land :	,						
	negist		-	0	THE PARTY	per per	ADVEL		_					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5.8.16a.b per 11 per 11 per 11 per 12 p

Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:48 PM September 2005 Butler Jorden Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birt**8**(Month, Dat Year)

Sept 22, 2005

Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1♥M 2□F 217-73-0512 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Item 27 is marked other than "natural", or Items 23s or 28s-1 show other treumstic event, the Medical Executors court be notified at 1 ☐ Yes 2 No Director MD Charles Newburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code fited within 72 hours after death with 11675 Edge Hill Road 20664 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 25 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event angue. Be Amie Marie Martin CLifton Danta Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22485 19a. Informant's Name/Relationship (Type, Print) 17051 Cromwell Pl.Apt.3D King George, VA Clifton D. Butler/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Ghost Cemetery 9/27/05 Issue, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypotension
Due to (or as a consequence of): Physician /Medical Examiner Dystunction lo days Myocardiai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner le days Seps15 Hospitel or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Extreme Prematurita 14 days Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Inharentricular hemorrhage 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 1 ☐ Yes 2 💢 No ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Boslan MD D0060780 September 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Carolyn Boylan, MD Johns Hopkins BMC, 4940 Eastern Avenue, Baltimore, MD Carolyn Boylan, MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day).

32. A gistrar's Signature

		State of Maryland / Department of Health and I State Registrar State Certificate of Death	Mental Hyg	iene 2005	31776
		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	th	3. Time of Death
Physicia		Gerald Douglas Brittingham	Septemb	Er 16, 200	5 2345PM
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
		Dorchester General Hospital Cambridge 5 Social Security Number 16 Say 7 Age (n yrs. last birthday) If Under 1 Year If Order 24 Hrs.	10 D (D) #	Dorche	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Gerider 24 Hrs. Months Days Hours Min.		, 1950 Mai	hplace (State or Foreign untry) Cyland
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
5-0036 Mellon Stands or 188-1 show with the Marylar "natural", or Hems 23a or 28a-1 show click for an institute notified at	ţō	Maryland Dorchester Fishing Creek			1 □ Yes 2 ☐ 110
th the	lrec	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	untry?
() () () () () () () () () () () () () (by Funeral Director	1607 Steamboat Wharf Rd. 21634		USA	· · · · · · · · · · · · · · · · · · ·
ter de litems	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
22 C 036 ours at all, or	by	If Yes, Give 1 ☐ Yes 2 ☐ M6 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify:	√hite
25 Era (a 215-0036 in 72 hours afte n "natural", or 1	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	rking	16b. Kind of Business/	Industry
	ldmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	.+	Seafood/Ele	ectrical
Id 2	Be Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, M	Maiden Sumame)	
Ylar	To B	Commercial Delianters	rude Rua		
Baltimore, Maryland 212. Baltimore, Maryland 212. Permit. Pages 1 and 2 should be filed withit Department of Health and Montal Hyglene. Important: If item 27 is marked other transitic event, the Manner.		Nancy J. Brittingham/Spouse 19b. Mailing Address (Street and Number or Ru 19b. Mailing Address (Street and Number or Ru 1607 Steamboat Wharf			
Te, I	1 3	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
Baltimore, Baltimore, Beariner, Pages 1 ar Bearineri of Hea Bearineri of Hea Bearineri of Hea Bearineri of Hea Bearineri of Hea Bearineri of Hea		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) OldTrinityChurchCemetery 9	/20/2005	Church Cr	aek MD
Balti Permit. Departm Importa	1 3	21 Fonature of Finance Service Licensee 22 Name and Address of Facility			SCR, TID
00 89 2 2 8 9 3	E	Wester Harak January Curran-Bromwell F 308 High St., Cam	bridge,	MD 21613	A
	£	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Acute /u/movery em/n//5	M		
Examiner					
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
xecute and II-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, te be ex ysician ne burial	ical E	d			
687 rtiflicating phy		IF FEMALE:			
30X ath cer ath cer ttendir	lan/N	23b. Was decedent pregnant in the past 12 months?		23d. Date of del Month	ivery Day Year
P.O. Box 68 nat the death certifica by the attending phetached for use as it	ysic	1 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown			
S, P, es that	by Physiclan/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
ord requir	eted	COSTRUCTIVE RIEEP MILE	1	es 2□No 3⊡197	
Division of Vital Records, I or Attending Physician: The law requires ta after cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed		24a. Was a autops perforn	med? prior to death?	topsy findings available completion of cause of
ital an: T rificate tor, pa	Φ	25. Was case referred to medical 26. Place of Dec	1 ☐ Yes 2 ath (Check only on	2 1 Yes	2@No
of Vi hysici his cer I direc	To B		lome 5 Reside	ence 6 □Other (Spe	cify)
on c ling P After ti		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Natural Superstriction Death (Month, Day Year) Superstriction Month (Month) Natural (Month) Nat	28d. Describe ho	ow injury occurred	
risic Attence death octor:	ficat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		treet and Number or Ru	ıral Route Number,
Div tal or s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town	n, State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge			
To th withir To th	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Monti	**
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		9-19-05	
		NINDAN THANKS 300 AUROR A CT CAMARIL	DGE T	10 216	13
Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 2005			

			For State Registrar	State of Maryland	l / Depa		Health and	Mental Hy	giene 005	31777
7	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Dea Month	Day Year	3. Time of Death
4 :	/Medic	cal	Garland Ray I 4a. Facility Name (If not institution, give	Bloomfield street and number)		4b. City, Town, o	or Location of De		er 14, 200 4c. County of De	
-	Exami	iei · · ·	Southern Maryland		cute	Clintor			Prince G	
	Funeral Director		5. Social Security Number 6. Sec			If Under 1 Year Months Days	If Under 24 H Hours Mi		1948 Ohi	rthplace (State or Foreign Sountry) O
	yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Maryland Prince G	eorge's Acc	okeek					1 □ Yes 2X No
	th with th	Funeral Director	1301 Pine Lane			10f. Zip Code 20	0607		10g. Citizen of What C USA	country?
980	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f show I'ra Madical Examinar musite rodified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 (2) Yes 2 (1) No ff Yes, Give Year or Dates: 1979 -		Was Decedent of H i Yes, specify Cub. □ Yes 🎾 No	dispanic Origin? an, Mexican, Pui Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	within ane. then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	Coffeee (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired ion Mecha	during most of w d)	vorking	16b. Kind of Busines:	
yland ;	be filed Ital Hyg Id othe avant,	To Be C	17. Father's Name (First, Middle, Last) Paul Bloomfield				Katheri		et Frazier	
	s 1 and 2 should if Health and Mer Itam 27 is marks other traumatic		19a. fnformant's Name/Relationship (Ty Margaret E. Bloomf					eek, MD 2	r, City or Town, State, 0607	Zip Code)
Baltimore,	9 0 = 5		20a. Method of Disposition 1	lemoval from State	netery, cren	sition (Name of natory or other place emetery	9-2	Date 0-2005	20c. Location - City of Bucyrus, C	
Ball	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service License	Mooo53		. Name and Addre	•		Box 156 orf, MD 206	04-0156
1000	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the death. ne cause on each line. a. CAUCEL Due to (or as a conseque	OF	the mode of dying		ac or respiratory are	est,	Approximate Interval Between Onset and Death
,09,	ate be executed hysicien and the burial-transit	Icai Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
.O. Box 68760,	death certific e attending p od for use as i	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. ff yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
rds, P	50.00	by	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the un	derlying cause giv	en in Part I.		pacco use contribute to	o fhe cause of death?
al Records,	The ste h page	Completed						24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of
ξ		o Be	25. Was case referred to medicaf examiner? 1 □ Yes 2 No	lospitaf: 1 ☐ Inpafient 2 ☐ EF	R/Outpatient	3C DOA Oth		eath (Check only on		
	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ation; To	27. Manner of Death 1 Naturaf 5 Pending 2 Accident Investigation		8b. Time of Injury	28c. Injun	y af		ence 6 Other (Spe ow injury occurred	cafy)
Divis	tal or Attars after de at Diracto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	the Hospital of the State of the Funeral Dipletely filled in	edical	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the within 2: To the complet	Σ	29b. Signature and title of certifier			29c. Licens		C C	9d. Date signed (Mont	h, Day, Year)
ſ			30 Name and address of person who con	mpleted cause of death (ftem 2	3a) (Tyne F	Print)	27 1.	4 2	CI I DULDE	L 1 11 COUS
	B1071	•	P. WISOTSW 31. Date fifed (Month, Day, Year)	RU-0 1207	0 0	D (10)	E CENT	ar Wi	RENEAF,	L 14, 2005 Ud. 20602
24	Sta Registr		SEP 1 6 20	32. Figistrar's Signatur	x Ag	ale				

State of Maryland / Department of Health and Mental Hyglen 205 31778 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SEPTEMBER Clark Romaine Barrow /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Cecil Rising Sun Calvert Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1XM 2□F 83 December 26,1921 213-16-4577 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Show ral, or items 23e or 28a-f show Examiner must be natified at 1 Yes 2 No Director Cecil Risina Sun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21911 1881 Telegraph Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: WW 11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: White "natural, or 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) Hygiene. Paper Shipping Clerk 11 t of Health and Mental Hygie If item 27 is marked other 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Eva Madeline Rink Robert Randle Barrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 West Main Street, Elkton, MD 21921 Donald Barrow/brother other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite,
any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brookview Cemetery 09-17-2005 Rising Sun, Maryland 22. Name and Address of Facility R.T. Fourd Funeral Home, P.A. 21. Signature of Funeral Service Lice 111 S. Queen St., Rising Sun, MD whara h /that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complicat shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) CANCER Physician Majo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical as the IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1) oment A page 2 autopsy performed? Yes 20 No 20 No certificate 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2X No Nursing Home 5 Residence 6 Other (Specify) 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) lhe. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certific SEPTEMBERO 15, 2005 428418 ddress of person who completed cause of death (Item 23a) (Type, Print) TRUGINOPH RD RISING SUN, MD 1831 KODNEY DONHAM 1).0 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 6 2005 Registrar

DHMH 17 Rev 1/2001

		State of Maryland / Department State of Maryland / Department State			2005	21770
		Tregional .	te of Death	Reg.	NOC UUJ	3. Time of Death
Physic	cian	Decedent's Name (First, Middle, Last) LINWOOD RONALD BROWN			Day Year	127122 R
/Med			y, Town, or Location of Death	36776464	4c. County of Deat	
Exam	iner		lkton		Cecil	
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unds	er 1 Year If Under 24 Hrs. s Days Hours Min.	(Month, Day, Ye	9. Birti 20 1953 Ma	hplace (State or Foreign untry)
Directo	r	219-62-9217		May 1/	1933 Ma	rýland
ow ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Many a-f sh	tor	MD Kent Galena				1 □ Yes 2√2 No
th the	Director		ip Code		Citizen of What Co	untry?
ath w			21635		J.S.A.	rican Indian
IL F. I.S. 19-0050 filled within 72 hours after death with the Maryland Hygiene. that than "natural", or Itams 23a or 28a-1 show ont, Its M. 21cal Examiner mat be maillised.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 ¹ No Specify:	Rican, etc.)	Black, White	
72 hour		15. Decedent's Education 16a. Decedent's Us			b. Kind of Business/	Industry
hin 72	Completed	(Specify only highest grade completed) (Give kind of w Elementary/Secondary (0-12) College (1-4or 5+)	vork done during most of work use retired)	ang		
ad with	Som	12 Linewo			Battery	Plant
	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
should be nd Mental marked o	2	Arthur E. Brown	EINOra ss (Street and Number or Rui	Ringgol		Zip Code) 21635
5 5 5 F F			assafras Ca			
Heal Heal thar		20a Method of Disposition (No.	ame of		Location - City or	
Pages nent of I		12 Burial 2 □ Cremation 3 □ Removal from State 14 □ Donation 5 □ Other (Specify)		6/05	alena,	MD.
	pi		and Address of Facility na Funeral			
Dan permit. Departi Import any inj		M00510 Gale	West Cross	St. Gale	stephen ena, MD.	21635
40000		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the moshock, or hear failure. List only one cause on each line.				Approximate Interval Between
Physician		Immediate Cause (Final disease or congettion a. Refrectory Carelro	~ / /	K	in in	Onset and Death
/Medica		resulting in death) Due to (or as a consequence of):	0 -			- ()
Examine		Sequentially list conditions, If any leading to immediate Due to (or as a consequence of):	eart trilune	2/		36 40015
be lisi	Jine	cause. Enter Underlying				06/10
xecut and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Lieung Carc Carcle Due to (or as a consequence of):	ourops thy			0 17040014
cate be executed bhysician and the burial-transil	dical	Coronary actory	deserve			U4/640W4
oo tificat g phy as the	ledlo				1	
The COLOS, F.O. DOX oc The law requires that the death certifics are has been signed by the attending phage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic	pregnancy		23d. Date of deli	*
that the death cered by the attendin	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (some past 12 months)			Month	Day Year
d by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying	r cause given in Part I	23e Did tohac	co usa contribute to	the cause of death?
w requires that been signed to should be dete	l by	Metastatic Pancreatic Carcer	cause given in rain.	1 ☐ Yes	-1/	obably 4 Unknown
w requires been sign should be	etec			24a. Was an	24h Were au	itopsy findings available
ne law has ge 2	Completed			autopsy performed	prior to death?	completion of cause of
VICAL ician: Th sertificate ector, pa	ပိ	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 A	No 1 Yes	2 No
VIII /sicia s cert	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I	Other	ome 5 Residence	e 6 □Other (Spec	cify)
g Phy gerthis	D: 1	27. Manner of eath 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how i	injury occurred	
andin ath. or: Af	atic	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
INISION Or Attanding after death, Diractor: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office	28f. Location (Stree City or Town, S		ıral Route Number,
pital of urs all paral Dilled i		Continue Physician To the best of an Insulated death assure	d at the time, date and place	and due to the caus	o(c) and manner as	stated
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2:	edical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) And manner stated.				
Fo the within Fo the	Me	29b. Signature and title of certifier	29c, License number		Date signed (Month	
. , , ,		aght ading my	00055190	50	:ptember	21,2005
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	pifal 106 Bac	s Statest	EIKto:	, , 40
S Regis	state strar	31. Date filed (Month, Day, Year) SEP 2 9 2005				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31780 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Cy **Physician** EVELYN LORRAINE BRITTINGHAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Peninsula Regional Medical Center Year WICOMICO Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Director 217-12-4617 82 August 10, 1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Worcester Berlin the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Iteme 23a 509 Flower Street USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: δ 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 2 should be fited within 1 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) Coflege (1-4or 5+) 11th laborer Poultry Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Harding Taylor <u>Annie Mary Pitts</u> 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any injury or other treum once. Elroy Brittingham, Sr./son 512 Flower Street - Berlin, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) St. Paul Ch. Cemetery | 0920/2005 | Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 2180123a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Finaf **Physician** disease or condition resulting in death) reprovoscu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 99 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attending Physicien: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending To the France after death.

To the Funerel Director, Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dunal and address of person who completed cause of death (ftem 23a) (Type, Print) Dounds stian 32. Registrar's Signature 31. Date filed 3EP 2. 922005 State Registrar

		1- State of Maryland / Department of Health ar Certificate of Death	nd Mental H	ygiene 8-9. 2 .005	31781
Physici	an	Decedent's Name (First, Middle, Last)	2. Date of I	Death Day Year	
/Medic Examin		Cierra Monique Beach 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	09 Death	4c. County of Dec	
Funeral	H	5. Social Security Number 6. Set 7. Age (In yrs. last birthday) It Under 1 Year It Under 24	4 Hrs. 8. Date of E	Wicon 9. Bi	1100 rthplace (State or Foreign
Director	g ,		Min. 8. Date of E (Month, I Sept.	17, 1998 Ma	ountry)
inyland show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Baltimore, Maryland 21215-0036 Departit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinars, and be nutified at once.	Funeral Directo	Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code		10g. Citizen of What C	1 Yes 2 XNo
uth with	a Di	626 Wellington Circle 21801		USA	
ter des	-une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	n? (Specify Yes or N Puerto Rican, etc.)	14. Race - Am Black, Wh	
DO36 lours at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: Bla	ack
Maryland 21215-0036 the 2 should be filed within 72 hours after the marked other than "natural", or traumatic event, the Mandic Exercit	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	of working	16b. Kind of Business	√Industry
1 21; lied with tygiene ther the		1st student	Nome (First Midde	le, Maiden Sumame)	
lanc uld be fi Aental F rked of tic eve	To Be		a Ann Mo		
Wary 12 shor h and h 7 Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of			
ore, M ss 1 and 2 of Health litem 27 i		Melissa Moore/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	- Salisbu Date	ry, Maryland 20c. Location - City of	
altimore, mit. Pages 1 ar opartment of Hem portant: If Hem a y injury or other		4 Donation 5 Other (Specify) Springhill MEm. Gdns 09	/23/2005	Hebron, Ma	ryland
Balt permit. Departimont import		21. Signature of Funeral Service Licensee JOLLEY MEMORIA			lisbury, MD 21801
		23a. Part 1. Enter the disease, or complications that caused the dyath. Do not enter the mode of a ring, such as ca shock, or heart failure. List only one cause on easy line.			Approximate Interval Between
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. — Condition Due to (or a **a bignesquence of):	200		Onset and Death
Examiner 52	L	I and the Amen			
Uted dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or 45 a consequence of): One of the conditions of th	n Hear	+ Desau	
5-53-92 8760, sate be executed physician and the burial-transit		resulting in death) Last Due to for as a consequence of):	/AI	Valie Tax	ed -
315-55 3x 68760 certificate be e dring physician tise as the buris	edica	d. Corgan Precent failur	1110	vane up	y
Box 6	lan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mop № ? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	olivery Day Year
P.O. I that the de detached f	Physician/Medical	1 Yes 2 No 9 Unknown 5 Other (specify) 9 Unknown		Month	Say 1 bai
Beach, 212 scords, P.O. Box 68 law requires that the death certific as been signed by the attending pl 2 should be detached for use as t	by	P II. Other significant anditions contributing to death but not resulting in the underlying care given in Part I.		tobacco use contribute to	
Becords, The law requires I is has been signs	Completed	Insufficience Complete Healthough	24a. Wa		robably 4 Unknown utopsy findings available
Vital Recipion The law certificate has	Com	Heart Failin Jutis and mary	per	opsy prior to death? 2 \(\text{No} \) 1 \(\text{Yes} \)	completion of cause of
. Crra. of Vital Physician: T	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Death (Check only	one)	1000
CIC on of ding Phys		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe	how injury occurred	city)
Division To Attending after death. Director: After	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, street, factory, office	28f. Location	(Street and Number or R	ural Route Number.
Div vital or urs afte		building, etc. (Specify)		own, State)	
Division of Vital Re Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, in my opinion, death and properties of examination and/or investigation, and the properties of examination and opinion an	place, and due to the occurred at the time	e cause(s) and manner as e, date and place, and due	stated. to the cause(s)
To the within To the comp	Me	29b. Signature) and unit of continue	1/2	29d. Date signed (Mont	h. Day, Year)
		30 Name and address of persen who gorpoleted cause of death (Item 23a) (Type, Print)	4 /	7.17	1
		Man Metalfalle-Eyo mo 1205 Pem Berton	Dr SULT	kin Ja	(MD2184
Sta Registr		SEP 2 9 2005			

Bowers,

				State of Ma					-		_	
			1 - For State Registrar		•	Certifica					.005	31783
			1. Decedent's Name (First, Middle, Las						2. Date of I			3. Time of Death
	Physici /Medi		Susan Pink						SEPTEM	BER 1		
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. Ci	ty, Town,	or Location of Death		4c	. County of Dea	th
		À	5. Social Security Number 6. S	onal dedice	(In yrs. las		der 1 Year		8. Date of 8	Birth	<i>W/COM</i> 9. Bir	OICO thplace (State or Foreign
	Funeral Director	9		□M 2 5 4,F	58	Yrs. Month	ns Days	Hours Min.	Feb.	Day, Year)	1947	Maryland
_	ъ		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Location						10d. Inside City Limits
00	Maryland -f show	ō	10a. State 10b. County MD Dorche		Too. Oily,	TOWN OF COCATION	Cam	bridge				1 ☐ Yes 2 🛣 No
b S	the h	rect	10e. Street and Number	CSCCI		10f.	Zip Code	bridge		10g. Cit	tizen of What Co	ountry?
$\mathcal{S}_{\vec{a}}$	3a or 28a	Funeral Director	14 Algonquin Re	oad				21613		÷	USA	
25	deatl	ner	11. Marital Status	12. Was Decedent En	ver in U.S.	13. Was De	cedent of	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or l	No-	14. Race - Ame Black, Whi	
36 6	or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2127 No tf Yes, Give	0		2 X No					white
- <i>700</i> - 21215-0036	72 hours after death natural", or iteme 23 dical Examiner mus	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a. Decedent's U	suai Occu	pation		16b. K	ind of Business	/Industry
7 515	n "na n "na Medic	plet	(Specify only highest gra			(Give kind of life. DO NO	work done	during most of work	king			
212	od within giene. er than "	Completed	12	5+		soc	cial y	worker			hospit	al
	be filed stal Hygi od other event, I	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam				
λς.γ γ	2 should be and Mental is marked o	To	Clifford R. P.			10h Mailing Addr	acc /Strao	C. EL:	izabeth			Zin Code)
<i>占いわ</i> り Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (James M. Bishop		bne			n Road, Ca		_		_
	is 1 and 2 of Health i item 27 i		20a. Method of Disposition		20b. Plac	ce of Disposition (/	Vame of		Date		ocation - City or	
Susand altimore,	Pages nent of int: ff ii		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			Trinity C			14/05	Chi	urch Cre	eek, MD
Susard Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licen	1500		22. Name	and Addr				al Home	
′ 6	205 2 3		Brink 15	ut				t St., Car			21613	Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line	ne death. e.	Do not enter the n				arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cons	ung	ナンビ	(OA	guiojan	HY			
	Examiner			Due to (or as a	conseque	rice or,			,			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	conseque	nce of):						
	be executed sicien and burial-translt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
760,	sicien a buriat-	a Ex	resulting in death) cast	Due to (or as a	conseque	nce of);						
387	physicale to physical		•	d								
×	leath certificate attending physi	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome o							23d. Date of de	livery
B	death e atte	Icia	in the past 12 months? 1 ☐ Yes 2 ØNo	1 ☐ Live birth 2 4 ☐ Pregnant at t				cy		-	Month	Day Year
P.O. Box 68	or Attending Physicien: The law requires that the death certificate siter death. Director: Atter this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medi	9 □ Unknown	9□ Unknown						1		
<u>v</u>	res fhe signed be de	þ	Part II. Other significant conditions of	ontributing to death but		ing in the underlyin	g cause g	iven in Part I.			•	o the cause of death?
oro	w requires been sign should be	Completed		00 (0	C	CITIA			24a. W		/	
Rec	hasi ge 2 s	dm							au pe	itopsy informed/?	death?	utopsy findings available completion of cause of
<u> </u>	ilcien: Th certilicafe rector, pag		25. Was case referred to medicat					26. Ptace of Dea		s 2 NA	1 ∐ Yes	s 2□No
ž	ysicien: The lis certificate ha director, page	To Be	examiner? 1 ☐ Yes No	Hospital: 1 Pripatien	t 2 🗆 El	R/Outpatient 3	DOA O	thor			6 ☐Other (Spe	ecify)
o _	ding Phy After thi funeral		27. Manner of Death 1 ★ Atural 5 Pending	28a. Date of Injury (Month, Day	/ 2	8b. Time of tnjury	28c. Inju	ury at ork?	28d. Describ	e how inju	ry occurred	
Siol	ttending Ph death. tor: After th the funeral	catle	€ Accident investigation 3 Suicide 6 Could not b			М	1 []Yes 2□No		(0)	-/	
Division of Vital Records,	or At after d Direct in by	Certification:	4 Homicide determined			ie, farm, street, fac	tory, office)		Town, State		ural Route Number,
u	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fur		29a. Certifier 1 Certifying Ph	ysicien: To the best of	f my knowl	edge, death occur	red at the t	time, date and place	, and due to the	he cause(s) and manner a	s stated.
	he Ho n 24 t he Fui pletely	edical	(Check only Z Medicat Exar	niner: On the basis of and manner stat		n and/or investigat	ion, in my	opinion, death occu	rred at the tim	e, date an	d place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of gertifier	Xia				nse number		29d. Da	ite signed (Mon	th, Day, Year)
				1			D 00	51743			04/1	
			As Davis E-	completed cause of de	ath (ttem 2	(Type, Print)	Garri	ou ST	Stris	Duy	s am.	1601
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	s Signatu	re	, ,	<u> </u>		/_		
	Regist		SEP 1	4 ZUUS > A	alus.	18 A	ande.	9				

			For State Registrar	State of Maryland	/ Department o		Mental Hygie	ZUUD .	31784
7	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las Moris Ube 4a. Facility Name (If not institution, give Shock Tram	Caceres.		n, or Location of Deat	2. Date of Death Month	Day Year 2005 4c. County of Death	3. Time of Death
*	Funeral Director		5. Social Security Number 6. Se N/A 12 Usual Residence of Decedent	7. Age (In yrs. las ☐M 2□F 20	st birthday) If Under 1 Ye Yrs. Months Da		8. Date of Birth (Month, Day, Y		lace (State or Foreign ltry) Salvador
	the Marylan r 28a-f ehow notified at	Director	10a. State 10b. County Maryland Prince (10e. Street and Number		Town or Location entwood 10f. Zip Cod	de	10g	. Citizen of What Coun	0d. Inside City Limits 1 X Yes 2 □ No
-0036	within 72 hours after death with the Maryland liene. r then "naturel", or Items 23a or 28e-f ehow the Medical Examiner must be notified at	by Funerai	4304 Bladensburg I	12. Was Decedent Ever in U.S. Armed Forces? 1Yes _ 2\frac{V}{2} No If Yes, Give Year or Dates:	207 13. Was Decedent If Yes, specify 0 1 XYes 2	of Hispanic Origin? (S Cuban, Mexican, Puen No <i>Specify:</i> E1 Sa1v	adorian	E1 Salvac 14. Race - Americ Black, White, 6 Specify: Wh. Kind of Business/Inc	an Indian, etc. nite
d 21215-0036	filed within 72 Hygiene. other then "ne ent, the Medic	e Completed	(Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		(Give kind of work do life. DO NOT use re Worker	one during most of worthing	ne (First, Middle, Mai	Construc	,
Maryland	s t and 2 should be Health and Mental Item 27 is marked of other traumatic even	To B	Ubel Caceres Gomez 19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Str	eet and Number or Ru		City or Town, State, Zip	Code)
Baltimore, I	Pages t and ment of Healt ent: if Item 2 uny or other		Marta L. Caceres/S 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	4304 Bladen ce of Disposition (Name or netery, crematory or other vs. Concepcion	place) n Ceni Sep	Date 2005	c. Location - City or To	lor
Balt	permit. Departi Import eny inj		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or sorn shock, or heart failure. List only	Demand	22. Name and Ad 11800 Ne	^{idress of Facilit} Hin w Hampshir	es-Rinaldi e Ave, Sil	i Funeral H Lver Spring	Home MD 20904 Approximate
8760,	Physician Medical Examiner physicien and phy	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Blund train. Due to (or as a conseque) Due to (or as a conseque) C. Due to (or as a conseque) Due to (or as a conseque)	a to Ahd ince of): ecleric ince of):			ammed and	Interval Between Onset and Death
P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 Ectopic pregna			23d. Date of delive Month	ny Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions or	ontributing to death but not resulti	ing in the underlying cause	given in Part I.		cco use contribute to th	1.7
tal Rec	The ate ha	e Completed	25. Was case referred to medical			36 Place of Do	24a. Was an autopsyl performa 1 Yes 2.2	prior to con death?	psy findings available npletion of cause of 2 No
Division of Vital Records,	utending Physideath. ctor: After this of the funeral dir	Certification: To B	examiner?	28a. Date of Injury (Month, Day Year) 2 1/2/2005 8	8b. Time of Injury 7. SS A M	Other: 4 Nursing H	lome 5 Residence 28d. Describe how Struck by	Loncre Ke	
۵	To the Hospitel or A within 24 hours after To the Funeral Directorpletely filled in by	edical Cer	29a. Certifier 12 Certifying Ph	ysician: To the best of my knowledger: On the basis of examination and manner stated.	edge, death occurred at th	e time, date and place ny opinion, death occi	130 Braddi	sh Ave 18:47	ated. the cause(s)
	To the within 2 To the Complex	Mec	29b. Signature and title of certifier 30. Name and address of prison who	1 0	> /	ense number	29d.	Date signed (Month, L	Jay, Year)
	Sta Registr		31. Date filed (Month, Day, Year)	339 Registrar's Signatur	s Greens St.	Suite SUDO	7 Bultimo	ce MP 2/2	0/

				partment of Health and Menta ertificate of Death	al Hygiene Reg. 2005 3	1785
	Physici		1. Decedent's Name (First, Middle, Last) Elsie Matleen Cole	Mo	ate of Death onth Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tember 17, 2005 4c. County of Death	5:45 P M
			1269 Ridge Road	Rising Sun	Cecil	
l	Funeral Director		5. Social Security Number 219-28-7107 Usual Residence of Decedent Continue of the contin	Months Days Hours Min /M	ne 14, 1932 Lanca	ster, PA
	nyland how		10a. State 10b. County 10c. City, Town or	_ocation	10d.	. Inside City Limits
	Re-f s	Director	MD Cecil Rising	Sun		1 ☐ Yes 2 💢 No
	with the or 2	Dir	10e. Street and Number 1269 Ridge Road	10f. Zip Code	10g. Citizen of What Country	?
	death ms 23	Funerai		21911 Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	es or No- 14. Race - American	Indian.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23e or 28e-f show or other traumatic evant, the Madical Examination at the Intelliged at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	etc.) Black, White, etc	
5-0	"netui	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Indus	try
12	within ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	tail Manager	Pau Comt	
9	illed Hygie other	a)	17. Father's Name (First, Middle, Last)		Boy Scouts Middle, Maiden Surname)	
Vlar	should be land Mental I smarkad or umatic eva	To B	Gaither Powers	Maggie Joh	hnson	
Jan	l 2 sho and ris ma			ling Address (Street and Number or Rural Route		ode)
_	1 and Health am 27		Roy G. Cole/husband 1269 20a. Method of Disposition 20b. Place of Disp	Ridge Road, Rising Su	200 Location City of Tour	Chata
<u></u>	Pages nent of I int: If its iry or o			position (Name of ematory or other place) 109-21-20 tingham Cemetery	Colora, Mari	
Baltimore,	permit. Pages 1 am Department of Healt Important: If itam 2 any injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility R.T. F	Foard Funeral Home	2, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	111 S. Queen Street,	Rising Sun, MD ratory arrest. Ac	21911 proximate
E	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. No tas atic A	bend Catical Caron		pproximate terval Between nset and Death
	Examiner		Due to (or as a consequence of):			
, ,	certificate be executed uding physician and use as the burial-transit	Examiner	Sequentially list conditions, it also, I sating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760	ate be hysicia the bu	dicai	d			
O. Box 6	law requires that the death certificate been signed by the attending p 2 should be detached for use as	Physician/Mec		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day	y Year
٠, ت	res that t lgned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	le. Did tobacco use contribute to the c	ause of death?
ğ	w require been slg should b				1 ☐ Yes 2 ☐ No 3 ☐ Probably	4 JUnknown
Hecords,	The ate h page	Completed			a. Was an autopsy prior to comple death?	tion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec.	k only one)	Komase .
ō	Phys this ral di	5. To	1		Residence 6 Other (Specify)	
0	Attanding I ir death. actor: After by the funer	atior	1 ✓ atural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	,	
DIVISION	e Hospital or Attano 24 hours after deatl a Funaral Diractor: etaly filled in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		cation (Street and Number or Rural Ro y or Town, State)	oute Number,
	Hospital	O	29a. Certifier 1 P Certifying Physicien: To the best of my knowledge, dea	hb		
	To the Hos within 24 hd To tha Fun completely	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at the	o to the cause(s) and manner as stated e time, date and place, and due to the	l. cause(s)
	To with	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,	, Year)
	h		30. Name and address of person who completed cause of death (Item 23a) (Type	D35453	7/20/03	
			Martha Hostord MD 111 W. Hig	h St. Stelo4 Elk	ton MD 219	2/
Ì	Sta Registra		31. Date filed (Month Spr Peg) 0 2005 32. Refistrar's Signature	h St. Ste 104 Elk		-

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Year **Physician** 23, 2005 Sept. Sister Mary Rose Chioka 8:55 P.M /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Emmitsburg Frederick St. Vincent Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) April 7, 1 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. 1916 Maryland 89 Director 231-68-0119 Usual Residence of Decedent permit. Pegas 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiena. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 □ No Director MD Frederick Emmitsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 335 South Seton Avenue 21727 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American I Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify. Š 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Religious Community Elementary/Secondary (0-12) College (1-4or 5+) Daughters of Charity College 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Theodore Chioka <u>Katherine Werner</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sister Camilla Harant 333 S. Seton Avenue, Emmitsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sep 26 1 Burial 2 □ Cremation 3 □ Removal from State St. Joseph's P.H. Cem. Emmitsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Skiles Funeral Home 210 West Main Street Emmitsburg, Md. 21727 23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physicien end I for use es the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? cata has been signed by the a page 2 should be detached 1 Yes 2 XNo 3 Probably 4 Unknown $\sim\sim$ þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificata has 3X) No t You 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 【XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending eftar death. 2 🗌 No investigetion 1 Yes 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital c within 24 hours of To the Funeral D completely filled i 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29b. Signature end title of 29c. License number 29d. Date signed (Month, Pey, Year) 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) Alan Carroll, M.D. 310 South Seton Avenue Emmitsburg, Maryland 21727

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) SEP 2 9 2005

. Registrer's Signature

Pleas

e T	Type or Print in Black Indelible Ink. Ensure A	Il Copies A	re Leg	gible.	
	State of Maryland / Department of Health and M	Mental Hygie	2e()	05	31787
	Certificate of Death		. No.		
Last)		2. Date of Death Month	Day	Year	3. Time of Death

Ph /N Ex

Fur

Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

/sici		 Decedent's Name (First, Middle, La 	ast)				2	. Date of Death	3. Time of Death	
		KATHERINE		CLO	UD		S	Month eptembe:	1:42 P M	
ledic amin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, o	or Location of			r 19,2005 4c. County of Deat	
	Ž.	Homewood at Wil	lliamsport		Will	iamspo	rt.	Washington		ton
eral		Social Security Number 6. 3	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth (Month, Day,		hplace (State or Foreign
ctor		220-07-2295	1□M X □F	86 Yrs.	Month's Days	Hours	"Ser	otember	21,1918 M	arvland
		Usual Residence of Decedent								
3		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
ii ii	5	Maryland Washir	ngton	William	sport			.,		1 ☐ Yes 2 ☐ No
3	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of What Co	ountry?
1		16505 Virginia A	Avenue		2179	5			U.S.A.	
9	Funeral	11. Maritat Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Orig	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
8	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X No		1 ☐ Yes 2X No	Specify:			Specify: Wh	
3	d by	3 ₩idowed 4 □ Divorced	Year or Dates:						Specify. Will	106
井	Completed	15. Decedent's E (Specify only highest gr		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	, 1	6b. Kind of Business/	Industry
4	Ig I	Elementary/Secondary (0-12)	College (1-4or 5+)		d)			0 11	
a		47 Fabrus Norra (First Middle Lan	1		omemaker	10 14-15-	d- \$1 /	Fire Middle M	Own Home	
9/6	Be	17. Father's Name (First, Middle, Las.	()	D11 3			,		aiden Sumame)	
natic	မ	Herman		Rosenthal			Kathe			Dietrich
Taur.		19a. Informant's Name/Relationship Jay B. Cloud							City or Town, State, 2	
hart			Son			riace			lle, Georg	
or of		20a. Method of Disposition 1 Description 3 D	Removal from State	1	natory or other pla		Dat		0c. Location - City or	
n y		*4 □Donation 5 □ Other (Speci		Hagersto		-			lagerstown,	, Maryland
any injury or other traumatic event, it a Medical Examitrer invest be notified at once.		21. Signature of Funeral Service Lice	7	Ã	2. Name and Addre	coffma	an Fu	neral H	lome, Inc.	
a a		A. hoel to	- 44	4	0 East Ar	ntietar	nı Str	eet. Ha	gerstown.	Md. 21740
			and the second second			- VIII	7.5			
ical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Chron	he death. Do not ent	er the mode of dyir	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between Onset and Death
ical ner	ner	Immediate Cause (Final disease or condition resulting in death)	a. Chrone Due to (or as a	he death. Do not ent	er the mode of dyir	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between
ical ner	aminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Chrone Due to (or as a	he death. Do not ent consequence of):	er the mode of dyir	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between
ical ner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a b. Due to (or as a c.	he death. Do not ent consequence of):	er the mode of dyir	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between
ical ner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a b. Due to (or as a c.	consequence of):	er the mode of dyir	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between
ical iner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	consequence of):	er the mode of dyir	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between
for use as the burial-transit	clan/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a b. Due to (or as a c.	tonsequence of): consequence of): consequence of): f pregnancy Fetal death 3	er the mode of dyir	lug	cardiac or r	respiratory arres	st,	Approximate Interval Between Onset and Death
for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. tf yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	tonsequence of): consequence of): consequence of): foregnancy Fetal death solutions of death solutions of the solutions	er the mode of dyin	ng, such as c	cardiac or r	respiratory arres	st,	Approximate Interval Between Onset and Death Co
for use as the burial-transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. tf yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	tonsequence of): consequence of): consequence of): foregnancy Fetal death solutions of death solutions of the solutions	er the mode of dyin	ng, such as c	cardiac or r	23e. Did toba	23d. Date of del Month	Approximate Interval Between Onset and Death Oset a
for use as the burial-transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. tf yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	tonsequence of): consequence of): consequence of): foregnancy Fetal death solutions of death solutions of the solutions	er the mode of dyin	ng, such as c	cardiac or r	23e. Did toba	23d. Date of delimenth	Approximate Interval Between Onset and Death Conset and Death Wery Day Year Obably 4 Unknown
should be detached for use as the burial-transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. tf yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	tonsequence of): consequence of): consequence of): foregnancy Fetal death solutions of death solutions of the solutions	er the mode of dyin	ng, such as c	cardiac or r	23e. Did toba 1 Yes 24a. Was an autopsy	23d. Date of delimenth	Approximate Interval Between Onset and Death Oset a
should be detached for use as the burial-transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. tf yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	tonsequence of): consequence of): consequence of): foregnancy Fetal death solutions of death solutions of the solutions	er the mode of dyin	ng, such as c	cardiac or r	23e. Did toba 1 Yes 24a. Was an autopsy	23d. Date of deliment of Month acco use contribute to 2 No 3 Processor 12 No 3 Processor 12 No 3 Processor 12 No 3 No 12 No 1	Approximate Interval Between Onset and Death O
should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	tonsequence of): consequence of): consequence of): foregnancy Fetal death solutions of death solutions of the solutions	er the mode of dyin	y ven in Part I.	cardiac or r	23e. Did toba 1 Yes 24a. Was an autopsy	23d. Date of deliment of the Month according to the Control of the	Approximate Interval Between Onset and Death O
director, page 2 should be detached for use as the burial-transit	e Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. tf yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	tonsequence of): consequence of): consequence of): f pregnancy Fetal death me of death not resulting in the unity.	Ectopic pregnancy Other (specify)	y ven in Part I.	of Death (23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2	23d. Date of deliment of the Month according to the Control of the	Approximate Interval Between Onset and Death Death Onset and D
director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at it 9 Unknown contributing to death but Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatier	Ectopic pregnance Other (specify) Inderlying cause grunderlying grunderlying cause grunderlying grunderlying cause grunderlying g	y ven in Part I. 26. Place oner: 4 Nurry at	of Death (vising Home)	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 Check only one	23d. Date of deliment of the Month 23d. Date of deliment of the Month 24b. Were auprior to death? 1 \(\) Yes	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Death Death Death Death Death Death Death Death
by the funeral director, page 2 should be detached for use as the burial-transit	ertification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatier t 2 ER/Outpatier y - At home, farm, str	□Ectopic pregnance □ Other (specify) □ nderlying cause given at 3□ DOA t 28c. Injur Mo 1□	y y y y y y y y y y y y y y y y y y y	of Death (sing Home)	23e. Did toba 11 Yes 24a. Was an autopsy 11 Yes 2 Check only one 5 Residen d. Describe how	23d. Date of delimental Month 23d. Date of delimental Month 24b. Were au prior to cleath? 1	Approximate Interval Between Onset and Death Death Onset and D
director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions AND CONTROL OF	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatier t 2 ER/Outpatier year) Tyear) Tyear) Tyear) Tyear, Tye	Ectopic pregnance Other (specify) Int 3 DOA At 28c. Injury M 1 reet, factory, office	y yen in Part I. 26. Place of the control of the	of Death (in sing Homes 28 to	23e. Did toba 1 Yes 24a. Was an autopsy The Property of the Color of Town, d due to the cau	23d. Date of delimental Month 22d. No 3 Proceedings of the Proceeding	Approximate Interval Between Onset and Death Death Onset and D

State Registrar gistrar's Signature

SEP 2 0 2005

		1	1 - State Registrar	State of Maryla		artment of F				31788
			Hegistrar Decedent's Name (First, Middle, Las	t)		unoate or	Douin	2. Date of De	Reg. No.	3. Time of Death
	Physicia				GGETT	JR		Month SEPT		05 10:55 m
	/Medio Examin		4a. Facility Name (If not institution, give		3017 1		r Location of Death		4c. County of	
	LAGITIII	G1	20621 Prathe			Gaithe	ersburg		MONTG	OMERY
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Year		8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		220-26-2610	XM 2□ F 7	5 Yrs.	Months Days	Hours Min.	Apr. 2	29,1930	Maryland_
	p ,		Usual Residence of Decedent 10a, State 10b, County	100	City, Town or Lo	ection				10d. Inside City Limits
	anyla shov	ž	MD Montg		•	nersburg	7			1 ☐ Yes 2 ☐ No
	Ba-f	Director	10e. Street and Number	Official	Curti		3		10- 0:1	
	with t			D		10f. Zip Code	2070		10g. Citizen of Wha	•
	eath ma 23	Funeral	20621 Prathe	12. Was Decedent Ever in	n U.S 13 \		0879 Jispanic Origin? (Sr	ecify Yes or No	U.S.A	American Indian,
	iter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes X (X No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
2-003b	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itema 23a or 28a-f show I'ne Medical Ezani, ar must be rediffed at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗗 No	Specify:		Specify:	Black
Ž	C/I IRE CH	Completed	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occup	pation during most of work	ring	16b. Kind of Busin	ness/Industry
7	within 72 ene. than "nai	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	d)		Distri	ct Court
7	ed wi	Con	12th		Coi	irt Clei			of Mar	yland
yland	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Surname) -	
Σ	Men Men arke	²	Isaac R. Cl					sie But		
Mar	2 sh and Is m		19a. Informant's Name/Relationship (7						er, City or Town, Sta	
ຜົ	t and lealth sm 27 shert		Sarah Claggett 20a. Method of Disposition			Control of the Contro		Date	20c. Location - Cit	rg, MD20879
Baitimore,	iges If ite		1 Burial 2 □ Cremation 3 □	nemoval num state		sition (Name of natory or other place				
	rtant		' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Lice)				em. 9/15			rsburg, MD Home, P.A.
g	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nn any injury or other traumatic event, Illu Metil 2005."		COMP K	Snowdy						e,MD20850
Е			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the d	eath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician	i i	Immediate Cause (Final disease or condition	LUNG C	ANCER					1 Year
	/Medical		resulting in death)	Due to (or as a cons	sequence of):					
	Examiner		Sequentially list conditions.	b						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
	and and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	sequence of):					
8/60,	icate be executed physician and s the burial-transit	alE								
28		edical	235	d						
×	law requires that the death certific as been signed by the attending p 2 should be detached for use as i	n/M€	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of	of delivery
n	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of]Ectopic pregnancy] Other (specify)	/ 		Month	Day Year
j O	at the de by the a tached	hys	9 Unknown	9□ Unknown						
_	res that igned b	by Р	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
cords,	w require been sig should b							1 X C)	Yes 2 No 3	☐ Probably 4 ☐ Unknown
ဝင	law re as be 2 sho	Completed						24a. Was autop	an 24b. We	re autopsy findings available r to completion of cause of
r	The lav	Com						perfo	rmed7 dea	th? Yes 2
VItal	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deal	h (Check only o	one)	
01	hys his	70	1 ☐ Yes 2 🛣 No		ER/Outpatien		4 Nursing Ho		dence 6 Other	(Specify)
	ding P h. After t funera	lon:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor		28d. Describe I	how injury occurred	
<u>s</u>	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be		t home form etc		Yes 2 □ No	28f Location /	Street and Number	or Rural Route Number,
DIVISION	al or A s after il Direction by	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	eot, ractory, office		City or Tox		or ridial riddle ridinger,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funera		(Check only 2 Medical Exam	ysician: To the best of my liner: On the basis of exam						
	thin 2 the 3 the mplet	Medical	29b. Signature and little of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (A	Month Day Year)
	£ ₹ 5 8		Jan Itx	amlou	0		061083			2,2005
١	5		30. Name and address of person who	completed cause of death (Item 23a) (Type		-0100		10141	,3
١	~		Paul Thankbi, M.		ical (en	ter Dr . 8	1e300 F	ockville	e. UD 20	X50
	Sta	te	31. Date filed (Month, Day, Year) SEP 15 20	32 Registrar's Si	gnature	M =	, O	LACLE COLUMN		
	Registr	ar	2FL 1 2 50	US Bour -	15. Bjos	ACL				

DHMH 17 Rev 1/2001

. , , ,			0.00	DMM 475	^
State of Maryland /	Department	of Health and N	Mental Hygiene	5 3	1/8

			1 - State Registrar			Cei	rtificate of	Death		Rag	g. No.			
			1. Decedent's Name (First, Middle, L	ast)					2.	Date of Death	Day	V	3. Time of Dea	ath
	Physici		E. Chin Chang						9	Month eptembe	Day er 13.	Year 2005	2:15 P	М
	/Medio Examir		4a. Facility Name (If not institution, g	ve street and nu	ımber)		4b. City, Town, o	r Location of		ереспис	4c. County		2.10	
	Exami	ici	Mariner Health			ring	Silver	Sprin	ď		Mont	gomer	~~~	
	Europel			Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24		Date of Birth (Month, Day,		9. Birthp	lace (State or Fo	reign
п	Funeral Director		220-76-0213	1 ☐ M 2 🕱 F	9	Yrs.	Months Days	Hours		an. 10		Cour	nny) Lina	
			Usual Residence of Decedent			J		1		an. 10,			LIId	
	show		10a. State 10b. County		10c. City	, Town or Lo	ocation					1	Od. Inside City Li	mits
	Man,	ō	Maryland Montgo	me ru	İ	C:1.,	er Sprin	~					1 ☐ Yes 2 ☐	JNo X
	149 288	Director	10e. Street and Number	JIIGI Y		DIIA	10f. Zip Code	y		10	g. Citizen of	What Cour	ntry?	
	With Man	٥	1005 Arcola Ave	1116			201	902			US	70		
	eath	Funeral	11. Marital Status		sedent Ever in U.	S. 13.1	Was Decedent of H		n? (Specify	Yes or No-		ce - Americ	an Indian,	
	iten	Ę	1 ☐ Never Married 2 ☐ Married	Armed F	orces? 2 ☑ No		If Yes, specify Cubi	an, Mexican, I	Puerto Ric	an, etc.)		ck, White,		
5-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show folcal Examination was be natified at	þ	3√2 Widowed 4 □ Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2√☐ No	Specify:			Specif	^{ʻy:} Asia	n	
ğ	thurs	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16	5b. Kind of B	usiness/in	dustry	
15	in 7	pie	(Specify only highest g) (1-4or 5+)	life.	kind of work done DO NOT use retired	during most o d)	of working					
2121	be filed within 72 ho tal Hygiene of other than "natul event, the Modical	E	12	College	(1-401 5+)	Hom	emaker					OwnH	ome	
0	Hygie Hygie Sther ent.	O	17. Father's Name (First, Middle, Las	it)				18. Mother's	s Name <i>(F</i>	irst, Middle, Ma				
an	d be ental	To B	Unknown Do					Ur	nknow	n				
Maryland	12 should be f n and Mental b Is marked of reumatic eve	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural R	oute Number, (City or Town	, State, Zip	Code)	
Ma	d 2 c		Chung Ni Ban /	Danaleta		1005	Arcola	Augnus	. 04	luor Cr	and more	MD 2	0000	
ė,	Heed Y		Chung-Ai Fan / 20a. Method of Disposition	Luaugnte	20b. P	lace of Dispo	sition (Name of		Date	20	c. Location	- City or To	wn, State	
ē	S TE S		1 Burial 2 Cremation 3		State		matory or other place		-	ber 16	_			S 8
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Importent: if Item 27 is marked any injury or other treumatic events.		*4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		Gate		ven Cemeter	-	2005	Sı	lver	Sprin	g, Maryl	and
Ba	Depa Depa Impo Impo Impo		21. Signature of unequired the		1. (F	Name and Address rancis J 00 Univer	Colli	ins F	uneral	Home :	Inc	MD 200	107
			23a. Part1. Enter the disease, or co	mulications that	caused the death							JI IIIG	Approximate	,01
н			shock, or heart failure. List on	y one cause on	each line.	i. Do not ent	or the mode or dyn	19, 30011 03 00	1.0100 01 10	ophetory and	,		Interval Betweer Onset and Deat	
	Physician		Immediate Cause (Final disease or condition	_a Cere	bral Ath	nerosc	lerosis							
	/Medical		resulting in death)	Due to	(or as a consequ	uence of):								
	Examiner		Sequentially list conditions,	b	1 Failu									
	D ==	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a nonsequ	ianes oty:								
	ocute nd trans	am	that initiated events	c										
ó	an a		resulting in death) Last	Due to	(or as a consequ	uence of);								
68760,	eath certificate be executed attending physiclan and for use as the burial-transit	Medical		d										
	rtifica ng ph as ti	Jed	15.55441.5									1		
Вох	0 2 3		IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Petal		Ectopic pregnancy	,				te of delive		
	deat e att	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)				Mc	onth	Day Year	
Ö	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physician	9 🗆 Unknown	9 Unki	nown									_
<u>ب</u>	es tha igned be del	by P	Part II. Other significant conditions	contributing to	death but not resu	alting in the u	nderlying cause giv	en in Part I.		23e. Did toba	cco use con	tribute to th	ne cause of death	1?
ğ	n sig									1 🗌 Yes	2 X No	3 🗌 Prob	ably 4 Unkn	own
Records,	w requir been si should	Completed							Ì	24a. Was an	24b.	Were auto	psy findings avail	lable
Re	The lav	Ē							-	autopsy	ed?	death?	mpletion of cause	, of
a			OF Man ages referred to modical					DC Dlace o	4 Daath (C	1 Yes 2	-	1 🗆 Yes	2 L No	
Vital		Be	25. Was case referred to medical examiner?	Hospital:		CD/0-1	oth	05		heck only one)		(0:4		
ō	Physic this ral di	<u>۲</u>	1 Yes 2 X No 27. Manner of Death	28a. Date	Inpatient 2 :	28b. Time of	IL SELDOA	4X INUIS		5 Residen Describe how			"	-
	ng the life in a	io	1 ☑Natural 5 ☐ Pending	(Mo	nth, Day Year)	Injury	Wor	k? Yes 2⊡No	1		,,			
Sic	Attending r death. ector: Afte by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be on Diag	o of Injuny - At ho	me farm etr	eet, factory, office		_	Location (Stre	et and Numb	oer or Rura	i Route Number,	
Division	or At fter (Jirec in by	Certification:	4 Homicide determine	d 200. Place	ding, etc. (Specify	()	eet, lactory, office		201.	City or Town,		707 07 17074	1110010 11011001,	
	urs a			No. of the last of		tille dest			-1	due to the service				
	Hosp 4 ho Fune Fune	ica	(Check only 2 Medicel Ex	aminer: On the	basis of examinat	wiedge, deati tion and/or in	h occurred at the tir vestigation, in my o	ne, date and p pinion, death	occurred a	at the time, date	se(s) and ma e and place,	and due to	the cause(s)	
	To the Hospitei or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and ma	nner stated.		29c. Licens	e number		290	I. Date signe	d (Month	Day, Year)	
	Twit or		29b. Signature and title of certifier	11									,/	
7	i		Mark	MA				27865	···	Se	ptembe	r 14,	2005	
			30. Name and address of person wh											
-			Mark K. Li, M.				Blvd, W,	Wheato	n, MI	20902				
	Sta		31. Date filed (Month, Day, Year)	100	Registrar's Signa	ture So	reles							
	Regist	rar	SEP 15 2	2005	WHILL IS	- PRING								

State of Maryland / Department of Health and Mental Hygie 2 05 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Philip Wardham Collyer 9:45 P M /Medical September 13 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wilson Health Care Center Montgomery Gaithersburg
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X**M 2□F Days Hours Min. Months 92 Director 127-01-8977 15 1913 New York Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examinating Landshied at Director MD 1 TYYes 2 □ No MOntgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 301 Russell Avenue 20877 United States

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Specify: White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Optical Engineer Engineer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is markad othing any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reginald Stanley Collyer Katheryn May Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley C. Collyer/Son 8817 Belmart Road, Potomac, MD 20854 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropalitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State September 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility DeVO1 Funeral Home, RACI Deer Park Drive, Gaithersburg, MD 20877 ul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovasa **Physician** 7 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai ď use a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown à page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Certification: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours To the Funeral 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 29b. Signature and title of permier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) teven Olinsto Russe Ave 6 aithers burg 31. Date filed (Month, Day, Year) Registrar's Signature State 15 SEP Registrar 2005

5-19-64-5-109 CARMEN DELCUADEO

			Please	Type or Print in B						le.
			1 - For State Registrar	State of Marylar		artment of I			giene Reg. No.	5 31791
	Physic		1. Decedent's Name (First, Middle, La Carmen De	el Cuadro				2. Date of De	_	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	re street and number)	40	4b. City, Town, o	or Location of Death	/	4c. County o	
	Funeral Director		5. Social Security Number 5.79-64-5709 6.9	Sex 7. Age (In yrs. 1 ☐ M 2 1 ☐ 7 7	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 7/16/	y, Year)	9. Birthplace (State or Foreign Country) Peru
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Wicomi		y, Town or Lo lisbu					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23e or 28 unt be no	Funeral Director	10e. Street and Number 30041 Rolling	Meadows Roa	d	10f. Zip Code 2180	4		10g. Citizen of Wr USA	nat Country?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Itema 23e or 28a-1 show any injury oceans traumatic event, the Midcel Eximiter must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ※ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☑ Yes 2☐ No	Hispanic Origin? (Spean, Mexican, Puerto F		14. Race Black,	- American Indian, White, etc. White
15-0	In 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of workind)	g	16b. Kind of Busi	ness/Industry
212	ed with ygiene. er thar t, ine A	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Tea	acher			Trade	School
land	ould be filed v Mental Hygie tarked other t tatic event, to	To Be	17. Father's Name (First, Middle, Last Guillermo Sift				18. Mother's Name Otilia		,	
, Maryland 21215-0036	and 2 should rath and Men 27 ie marke er traumatic	-	19a. Informant's Name/Relationship (Franklin Step)		19b. Mailin	g Address <i>(Street</i> 05 Ashl	and Number or Rural ey Drive	Route Number	er, City or Town, St	d 20852
Baltimore,	Pages 1.2		20a. Method of Disposition 1 ☐ Burial 2 ⑤ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State	emetery, cren	sition (Name of natory or other place ake Cre	се) em. 9/14/	2005	20c. Location - Ci	ity or Town, State
Balti	permit. Departn Imports any inju		21. Signature of uneral Service Lice	00	22 P1	Name and Addre	ss of Eacility LDI	FUNE	RAL SERV	VICE P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a. Due to (or as a consequence)	Do not ente	or the mode of dying	umbia Bi ng, such as cardiac or	VC S 1 respiratory ar	Iver spi	Approximate Interval Between Onset and Death
	icate be executed physician and s the burlal-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of April 1) that initiated events resulting in death) Last	c. Due to (or as a consequent	pence of):	tie O	barian	Car	yels	
j.	the death certify the attending ached for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date o Month	
ras, r	De lo	by	Part II. Other significant conditions o	ontributing to death but not resu	Ilting in the un	derlying cause giv	en in Part I.			ute to the cause of death?
l Kec	The law ate has b page 2 st	e Completed	25. Was case referred to medical						med? prio dea 1 □	re autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \) No
ō	ng Phys fter this ineral di	ertification; To B	examiner? 1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Work	4 □ Nursing Home	5 ☐ Reside	ne) ence 6 □Other (ow injury occurred	(Specify)
	tal or Att rs after de al Directe ed in by t	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office	28	f. Location (Si City or Town	treet and Number on, State)	or Rural Route Number,
:	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai	one)	ysician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the times as igation, in my or	ne, date and place, an pinion, death occurred	d due to the c at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
1	7/	Σ	29b. Signature and title of certifier	ND D. K	M	29c. License	number 52/98	2	9d Pate signed (A	fonth, Day, Year)
			30. Name and address of person who	111/11/11/11	+ 10	12111	51. SM	115h11	y ms	
H	Sta Registra		31. Date filed (Month, Day, Year) SEP 15	32. gistrar's Signate	1. Ap	enti		/		

			1 - For Registrar	State of M	laryland /		artment of I	Health and N		- 200	5	31792
			Decedent's Name (First, Middle, Last)		-		imeate of	Death	2. Date of Dear	eg. N o. O O		3. Time of Death
	Physic		Evelyn W. DeShield	is					Month	per 11,	Year	
	/Medi Examir		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town,	or Location of Death	Septemb	4c. County		435 P™
			Snow Hill Nursing	& Rehal	b Cente	r	Snow :	Hill			ceste	er
	Funeral		Social Security Number 6. Sex		ge (In yrs. last i	birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,			ace (State or Foreign
	Director		219-05-3857	1 2⊠F		87 ^{rs.}	Worth Days	riours Miri.	Nov 8,			w Hill
()	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				14	od Janie City III
	Many!	٥	MD Wicomic	2		isbu					10	od. Inside City Limits 1 X Yes 2 No
	death with the Maryland me 23a or 28a-f ehow Emust be notified at	Director	10e. Street and Number		Jar.	TSDU	10f. Zip Code			0- Ciri614	(1-1-0	
	with Ba or		30342 Dixon Rd.					1	'	0g. Citizen of W		ry r
	death The 2:	Funeral		Was Decedent	Ever in U.S.	13. V	2180°		acriv Yes or No.		S.	n Indian
g	or Ite	Ē	1 Never Married 2 Married	Armed Forces:	?			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	c, White, e	tc.
03	ral'.	d by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 21 No	Specify:		Specify:	Blac	k
2-0	72 h	Completed	15. Decedent's Educat (Specify only highest grade of		16	a Deced	ent's Usual Occup	pation during most of work	ring	16b, Kind of Bus	siness/Ind	ustry
12	vithin Pon Pon Pon Pon Pon Pon Pon Pon Pon Po	m	Elementary/Secondary (0-12)	College (1-4or	5+)	life. [OO NOT use retire	d)	9	-		
2	ited y		7 17. Father's Name (First, Middle, Last)			Don	mestic			Privat		milies
Maryland 21215-0036	d be i	Be	James E. Harmon					18. Mother's Nam	e (First, Middle, N Turrea])	
2	should Me mark	2	19a. Informant's Name/Relationship (Type,	Print)	10	9h Mailin	Address /Street	and Number or Rur			74.4. 77.	2.71
×	ulth ar 27 is r trau		Mable Teagle/Niece	-				n Rd., Sal				J009)
نو	S 1 a f Hear item		20a. Method of Disposition			of Dispos	ition (Name of			20c. Location - C		vn, State
ě	Page nent o nt: If		1 ⊈Burial 2 ☐ Cremation 3 ☐ Rem 1 ☐ Donation 5 ☐ Other (Specify)	oval from State	Mt.	Wes]	ey U.M.(- I		Snow Hi		
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insportment of Health and Mental Hygiene. Insportment of Health and Mental Hygiene. The maryland is the marked other than "natural", or Itema 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signatur of Funer II Service Licensee		Ceme	etery	Name and Addre	ss of Facility			.11,	.ш./
00	Departiment of the police of t		100				Lewis N.	Watson E st Road, S	uneral F	Iome 7 MD 21	801	
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one	ions that caused	d the death. Do	not ente	r the mode of dyir	ng, such as cardiac	or respiratory arre	st,		Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	0	emen	ti.	_					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):						
	d - 5	_	Sequentially list conditions, b	Dug to for an	a consequence							
_	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	a Othe						
ď	execunand nand ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequence	e of):					-	
. FJ	cate be executed physician and the burial-transit	dicai	d.									
3 8		ledi										
7 X	death certific e attending p id for use as	an/N	200. Tras decedent program	If yes, outcome	of pregnancy 2 Petal deat	h 3⊡i	Estania organia			23d. Date	of deliver	,
, , , G	0 0 0	sicia	in the past 12 months? 1 ☑ Yes 2 ☐ No	4 Pregnant at			Ectopic pregnancy Other (specify)	/		Monti	n D	ay Year
ا م	that the deed by the detached	Physician/Me	9 Unknown									
્ર ds,	ires the signe	by	Part II. Other significant conditions contrib	outing to death b	out not resulting	in the uni	derlying cause giv	en in Part I.				cause of death?
()	w requir been s should	etec							-		Probat	oly 4 Unknown
Rec	has has	Completed							24a. Was an autopsy perform	pri	or to comp	y findings available pletion of cause of
<u>a</u> 3			25. Was case referred to medical						1 ☐ Yes 2	ZNo 1	ath? Yes 2	□ No
್ವೆ.	ysiclan is certifi director	o Be	examiner? 1 Yes 2 No Hosp	oital:			3 DOA Oth	26. Place of Death				
3 5	g Phy er this	н,		1 ☐ Inpatie	ry 28b.	Time of	3 DOA 28c. Injun	44-Nursing Ho	me 5 Resider 28d. Describe hov			
M P	Attending Physiclan: r death. sctor: Atter this certifica by the funeral director.	atio	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	y Year)	Injury		k? Yes 2 □No		, with a second		
Division		Certification:	3 Suicide 6 Could not be	8e. Place of Injude	ury - At home, f	arm, stree	et, factory, office		28f. Location (Stre	et and Number	or Rural F	Route Number,
Ö	spital or Al burs after of leral Direc filled in by	Cer		Dullaling, et	c. (Specify)				City or Town,	State)		
	Hospital or 14 hours afte Funeral Dir tely filled in	edical	29a. Certifier Certifying Physicia (Check only one) Certifying Physicia Examiner.	On the basis of	i examination at	e, death a	occurred at the time	ne, date and place, a	and due to the cau	ise(s) and mann	er as stat	ed.
	the ple	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. License					
	To To To To To To To To To To To To To T		30	Mylen	D			4422	290	d. Date signed (Month, De 1 3 ーご	The same of the sa
	The state of the s	4	30. Name and a male of person who come	efer BAP	eat (Hem 23a)	(Tues B		7402		3 -		٠
	h		1604-Market	St.	4	Type, P	1	MD.	21851			
	Sta		31. Date filed (Month Ser Per) 6 200	32. Pojistra	ar's Signature							
	Registra	ar	1 0 200	Alak	m H	A	willer					

			1 - State Registrar	State of Maryland / Depa	artment of Health			iene 2005	31793					
			Decedent's Name (First, Middle, Last)			2	. Date of Deat	h	3. Time of Death					
	Physici		George Davis	Jr.		C.	Month	Day Year	1101 AM					
}	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location		ebreun	4c. County of Deat						
			Prince George H	osnital	Cheverly			Prince (~~~~~					
	Funeral		5. Social Security Number 6. Sex		If Under 1 Year II Und		. Date of Birth	9. Birt	hplace (State or Foreign untry)					
п	Director		259-42-3394 ¹⁸	M 2□F 85 Yrs.	Months Days Hour		(Month, Day,	1919 Geo	untry)					
	P.		Usual Residence of Decedent					1313 1060	ryra					
	how	_	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits					
	Ma	cto	Md Prince (George Ft. Was	hington				1. X Yes 2 □ No					
	or 28	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What Co	untry?					
	15 wi	ai	9711 Jacqueline	Drive	20744			USA						
	ems ems	Funeral		2. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexi	Origin? (Specif	v Yes or No-	14. Race - Ame Black, White						
9	afte or It	F.	1 Never Married 2 Married	1 X Yes 2 No	☐ Yes 2 No Spec		Julii, 515./							
ဗ္ဗ	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jiçal Exar, it set must be melliked at	d by	3 X Widowed 4 □ Divorced	Year or Dates:				Specify: B1	ack					
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than natural; or Items 23a or 28a-1 show other than natural; or Items 23a or 28a-1 show awant. It a Musical Exact it at most be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Deced completed) (Give	lent's Usual Occupation kind of work done during n DO NOT use retired)	most of working		16b. Kind of Business/	_{Industry} on,Military					
2	within ene. than "	ш	Elementary/Secondary (0-12)	College (1-4or 5+)				Base, Augu	-					
	e filed v ti Hygie other t vent, L		12th 17. Father's Name (First, Middle, Last)	Mecha		leate a bloom of			GCG GA.					
anc	ould be fi Mental H arked ot atic ever	Be						Maiden Sumame)						
Maryland	s 1 and 2 should be f Health and Menta item 27 Is marked other traumatic ev	L 0	George Davis Sr			orgia	Dukes							
Ma	d 2 st th and th s n traun			oe, Print (Daughter 19b. Mailin				City or Town, State, 2	lip Code)					
	of Healt item 2 other		Pamela Davis Date 20a. Method of Disposition		Jacqueline			sh, Md.						
ō	m O		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State cemetery, cren	natory or other place)	a			,					
Ħ	t. Pa tmer tant njury		'4 □ Donation 5 □ Other (Specify)	Walker G	rove Churc	chSept	19,05	Keysvil	le GA.					
Baltimore,	permit. Page Department Important: Il any injury o		21. Signal of Funer of Service License	1	. Name and Address of Fa									
	au = * a		sprone 1.	Mur Ty	rone J. Yo									
ļ	- 1		23a. Part / Exter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shork, or heart failure. List only one cause on each line. Approximate Interval Between											
	Physician		Immediate Cause (Final disease or condition	Myocan dia	Unter	c tm	n all	ute	Onset and Death					
	/Medical Examiner		insequentially list conditions. a. My O (and dual Implement from all the consequence of): Due to (or as a consequence of): Provable Pulman Embalum b. Provable Pulman Embalum											
Н	LXairiiie	_	Sequentially list conditions, b.	1000 kle 1	Ulman	CN	nbou	(ww						
	Sit 9d	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	0.	U.L.								
	and tran	сап	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):	anger	7/ TVY	ν)							
58760,	icate be executed physician and s the burial-transit	E		Dide to (or as a consequence or):	11110, L	1 -								
87	cate ohysi the t	dlcal	d.	DOUBLE ALS	rocco (c	10								
	h certific anding p use as		IF FEMALE:	la If you autooma of programmy										
Вох	eath certif attending for use as	ian	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of deliments	very Day Year					
P.O.	res that the de signed by the a I be detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	Other (specify)				.,					
σ.	hat ti	P		ributing to death but not resulting in the un	derhing cause given in Pa	art i	23a Did tob	acco use contribute to	the sauce of death?					
Records,	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	l by		in the district resetting in the dis	denying dadde given in ra	art c.		V	bably 4 Unknown					
0	w requir been si should	etec												
Sec.	e law has t	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of					
=	: Th	Ö					perform 1 Yes 2	ed? death? No 1 ☐ Yes	2□ No					
Vital	ding Physician: The i.h. h. After this certificate ha funeral director, page	Be	25. Was case relerred to medical examiner?	- No.		lace of Death (C	heck only one							
<u></u>	shysi this c	၉	To res 2000	ospital: 1 Inpatient 2 ER/Outpatient				nce 6 ☐Other (Spec	ify)					
C C	ing F	on:	27. Manner of Death\ 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?		I. Describe hov	w injury occurred						
Sic	tend leath tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2									
Division of	fter of firect pirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	281.	Location (Street) City or Town,	eet and Number or Rui State)	al Route Number,					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i		V											
	Hosp 14 ho Fune Fune	ica	(Check only 2 Medicel Exemin	cien: To the best of my knowledge, death er: On the basis of examination and/or inv	occurred at the time, date estigation, in my opinion, d	and place, and death occurred:	I due to the car at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)					
	thin 2	Medical	one)	and manner stated.										
	5 × × 0		29b. Signature and title of certifier	Too	29c. License numbe	C ()		d. Date signed (Month						
	(2)		> Stur		1409	90		egreen se	14/2003					
K	(6)		30. Name and address of person who con	npleted cause of death (Item 23a) (Type, F	Print)	PT N	VOIL	11/2 1100	20782					
			31. Date filed (Month, Day, Year)	2. Registrar's Signature	mu tin	3 1 17	17417)	VIIU JUVY	00/02					
	Sta Registra		SEP 1.6 2005	State & Signature	- 62									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 5

			1 - State of Ma		artment of Health and rtificate of Death		gien 2005	31794
	_		Decedent's Name (First, Middle, Last)			2. Date of Dea	th	3. Time of Death
	Physici /Medic	al	Rosella Jane Denton 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	Septemb		
	Examin	er				atri	4c. County of Dea	
	Funeral		Washington County Hospital 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)			Washingt	thplace (State or Foreign
	Director		214-36-0759	68 Yrs.	Months Days Hours Mil	n. (Month, Day Sept 8	, Year) C	yland
	pu ,		Usual Residence of Decedent					
	ehov	Ž	10a. State 10b. County Maryland Washington	10c. City, Town or Lo				10d. Inside City Limits 1 Yes 27 No
	the M	Director	10e. Street and Number	nagerstow	10f. Zip Code		log. Citizen of What C	
	with a or	ia		0.5				ountry ?
	death	era	11400 Stonecroft Ct. Apt 30	Ever in U.S. 13.	21742 Was Decedent of Hispanic Origin?	Specify Yes or No-	SA 14. Race - Ami	erican Indian,
စ	or Ite	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2001 If Yes, Give	No	If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, Whi	
93	iral',	d by	3 XWidowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 No Specify:		Specify.Whi	te
5-	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking	16b. Kind of Business	/Industry
12	withir ane. than	mp	Elementary/Secondary (0-12) College (1-4or 5	(T)	inistrator		Government	. US
d 2	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28e-f ehow other than "natural", or Items 23a or 28e-f ehow event. Ite Madical Examiner must be multired at	e Co	17. Father's Name (First, Middle, Last)			ame (First, Middle, I		,
lan	lid be lental ked c	To B	Harry Nelson Stickell		Millie		11120	
ary	shou and M s mar umat	, –	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or F		, City or Town, State,	Zip Code)
Σ	and 2 saith a n 27 i		Henry Stickell/Nephew	24 H	ighview Dr. Wood	bridge NJ	07095	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow amy njury or other traumatic event. It a Marcical Examiner must be multilised at once.	1	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date	20c. Location - City or	Town, State
Ē	Pag tment tent: lury o		` 4 ☐Dopation 5 ☐ Other (Specify)			9-05	Hagerstown	MD
3a	Separation of the control of the con		21. Sin the of Funeral Service Licensee		2. Name and Address of FacilityRe			
	uoz s u	_	23a. Part1. Enter the disease, or complications that caused		601 Pennsylvania			
bj	Prysician		shock, or heart failure. List only one cause on each lin	NIC REA		E	esi,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a consequence of):	701	,,,		9 6 1 6
		-	Sequentially list conditions, if any, leading to immediate b. Due to for as a	a consequence of):	//0			YEARES
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	R2A 11	ASWIAZ ACC	MENL		LEAZI
Ć,	exection and ial-tra	Exa	that initiated events c. Due to (or as a	a consequence of):	17001 11	71170110		GEBIO
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai						
9	rtifica ng ph as th	Ф	IF FEMALE:					
30X	ath ce ttendii or use	an/	23h Was decedent organism 23c. If yes, outcome		Ectopic pregnancy		23d. Date of de	
Vital Records, P.O. Box	that the death certificed by the attending properties as	by Physician/M	1 ☐ Yes 2 Ø No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)		Month	Day Year
٦.	that the ad by detac	Ph)	Part II. Dther significant conditions contributing to death but	ut not resulting in the u	nderlying cause given in Part I	23e. Did tob	pacco use contribute to	the cause of death?
ds,	uires tha signed Id be det		MASINITIC	, , , , , , , , , , , , , , , , , , , ,	naon, mg cadoo giron iin nann ii	1 □ Ye	1	obably 4 Unknown
COL	w requir been s should	lete	V			24a. Was a	n 24h Were au	stoney findings available
Re	he lav e has age 2	Completed				autops	ned?// death?	stopsy findings available completion of cause of
ta		a	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 eath (Check only on		2 No
\(\)	Physici this cer al direc	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 DER/Outpatier	Other		ence 6 □Other (Spe	cify)
0	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injur (Month, Day	y 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sio	tendi leath. tor: A the fu	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division of	or At offer d Direct in by	Certification:	4 Homicide determined 28e. Place of Inju	ury - At home, farm, str c. (Specify)	reet, factory, office	28f. Location (Sti City or Town	reet and Number or Ru n, State)	ıral Route Number,
_	To the Hospital or Attending Physician: whith 24 hours after deals at the feath To the Funeral Director. After this certifica completely filled in by the funeral director,		29a. Certifier 1 certifying Physician: To the best of	of my knowledge death	h occurred at the time, date and class	e and due to the ca	use(s) and manner or	stated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medicel Exeminer: On the basis of and manner sta	examination and/or in	vestigation, in my opinion, death occ	curred at the time, da	ate and place, and due	to the cause(s)
	To th To th comp	₩	29b. Signature and title of certifier		29c. License number		9d. Date signed (Mont	h, Day, Year)
	۸ ۸		► 1/Wig[], ///OK	1514	1) (10220	43	9/16/0	5
,	3		30. Name and address of person who completed cause of de	eath (Item 23a) Type.			1 7.	11/7
			31 Date filed (Month Day Year)	MUS KI)		U(V/V /1	110 611	46
	Sta Registra		31. Date filed (Month, Day, Year) SEP 19 2005 32. Fegistra	ar's signature	refe			

State of Maryland / Department of Health and Mental Hygiene Reg. **2.**005 State
Registra MEND#8perFH9/16/05, EMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SEPT 6, 2005 12:20 AM NORMAN Н. DORSEY, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital MONTGOMERY Rockville If Under 1 Year If Under 24 Hrs. year 943 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1∏M 2□F 62 220-40-6874 Director Marvland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rel', or items 23e or 28e-f ehow Examinational be notified at Yes 2□No Director MD Dickerson Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20500 Beallsville Road 20842 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2∕21No fYes.Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 Widowed 4 Divorced Year or Dates: neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages I and Mental Ingered Department of Health and Mental Ingered other the importent: If item 27 is marked other threngy or other treumetic event, ILS and. Sanitation Worker Refuge Co. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Russell 2 Christine Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Dorsey (Wife) 20500 Beallsville Rd., Dickerson, MD 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Metro/Crematory 9-10-05 Alexandria, VA 5 Other (Specify) ☐ Donation Signature of Funeral Service Licens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/ List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician **Physici** /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onseque ce of) Examiner The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to o as Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 🗌 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28h Time of After 1 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Director: Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check or one) and manner stated 29c. License number 29d. Dafe signed (Month, Day, Year) 29b. Signature and title of certifi an impleted cause of death (Item 23a) (Type OR State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	larylan			nt of H		and Me		giene		3	179	16
	Physici	an	1. Decedent's Name (First, Middle, Las Myra Jean Deal	st)							2. Date of De Month eptemb	ath Dav	/ Ye	aar	3. Time of D	
	/Medic	cal	4a. Facility Name (If not institution, give	street and number			4b. Cit	y, Town, or	Location o		epreno		County of E		1:43	Α
	Exami	lei	8609 South Bali (,			icott				1	oward			
	Funeral Director		5. Social Security Number 6. Security 1 6. Security Number 1	ex 7. A □ M 2	ge (In yrs. 83	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under a	Min.	8. Date of Bir (Month Da 11/8/1	th 921		Birthplac Country aryla	e (State or and	Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d	l. Inside City	Limits
	Maryl	tor	MD Howard		El	licott	Cit	У							1 ☐ Yes 2	2 X No
	or 28s	Directo	10e. Street and Number		-1			Zip Code				3	zen of Wha	t Country	1?	
	e 23e		8609 South Bali Co	ourt 12. Was Deceden	t Ever in II	C 13.1		1043	enanic Orio	nin? (Sne	effy Yes or No	US.	A. 14. Race - /	American	Indian	
36	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23e or 28e-f ehow ent, the Maulical Examiner must be molified a	by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 Yes 24 If Yes, Give Year or Dates	i?] No		f Yes, sp	2 No	n, Mexican	, Puerto F	Rican, etc.)			White, etc	Э.	
ခို	2 hour	ted t	15. Decedent's Ed	lucation		16a. Deced	ient's Us	sual Occupa	ation	t of workin		16b. Ki	nd of Busin			
212	ithin 7. 18. 19. "n	Completed	(Specify only highest gra	College (1-40)	r 5+)			vork done d use retired))	OI WOIKIII	g	_				
7.0	e filed within Hygiene. other then	Col	17. Father's Name (First, Middle, Last)			Hamer	llake	T.	18. Mothe	r's Name	(First, Middle,		wn Hon Sumame)	ne _		
la la	e d la	To Be	Maynard Stewart	Lauterba	ch				Mvra	Char	oman					
Maryland 21215-0036	s 1 and 2 should 4 Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Туре, Print)			-		and Numbe	r or Rural	Route Number					
	1 and 1ealth 1m 27 ther tr		Rev. Stewart W. De 20a. Method of Disposition	eal/Husba		_8609 \$			i Cou		Ellicot		ity, M			
פֿר	0 0		1 ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		9	cemetery, crer	natory o	r other plac		/10/	2005				Le, MD)
Baltimore,	permit. Pag Depertment importent: i eny injury o once.		21. Signature of Funeral Service Licen		Cre Duun		. Name	and Addres	s of Facility	Harry	7 11 W	itzke	e's Fa	mily		nc.
12			23a. Part1. Enter the disease, or compensation of the compensation	plications that cause	ed the deat	h. Do not ent	er the m	ode of dying	g, such as	cardiac or	respiratory a	rrest,		A	pproximate	een
	Physician		Immediate Cause (Final disease or condition			r's Der	nent	ia						0	year	
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):									-	
	\$ 15	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oua to (or a	s a conseq	wence of):										
	nd nd transit	Examiner	that initiated events	c. =												
3/60,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):										
289	ificate g phys as the	edical		. d.								- 1				
ž g	death certificate be executed e attending physicien and ed for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic Other (pregnancy specify)				:	23d. Date of Month	delivery Da	ay Ye	ar a
J.	d by the deletached	Phys	9 ☐ Unknown Part II. Other significant conditions c		but not sac	ulting in the u	ndorheine	L COLLEG CIV	on in Part I	1177	23a Did t	obacco u	ise contribut	te to the	cause of dea	ath?
ecords,	w requires that been signed b should be deta	ted by	Part II. Other significant conditions	ontributing to death	Duttioties	anting in the di	nderly ing	, cause give	X			Yes 2		Probab		
Hecc	The law te has b age 2 si	Completed									24a. Was autor perfo		prior	to comp	y findings av letion of cau	vailable use of
Vital H		BeC	25. Was case referred to medical examiner?							of Death	(Check only o					
5	Phys this aldi	2	1 ☐ Yes 2 🛣 No 27. Manner of Death			ER/Outpatier 28b. Time of			4 140		e 5 Resi			Specify)		
0	ding th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	М	28c. Injury Work 1 🔲 '	(? Yes 2 □t				,			
DIVISION	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of I	njury - At ho etc. (Specif	ome, farm, str	eet, facto	ory, office		2	8f. Location (: City or To			r Rural R	Route Number	Θ/,
	Abospitel 24 hours a Funerei etely filled	edical C		ysicien: To the bes	of examina											
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Dat	e signed (M	fonth, Da	y, Year)	
2)	~ n	N.D			D50	531			9/17	7/2005	,		
)(20		30. Name and address of person who							010						
	Sta	ite	31 Date filed (Month Day Year)	Kic ory 1	KIDGE trar's Signa	Rd.,	Col	umbia	, MD	2104	14					
	Registr		SEL I 8	2005	Eur.	ature .	DEAL	2								

			- FOI	partment of Health and Nertificate of Death	Mental Hygien	16/16 600
	Physicia	an	Decedent's Name (First, Middle, Last)			ay Year
	/Medic	al	Elva Lorinde Dauber	4b. City, Town, or Location of Death	September	14,2005 21:34 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Union Hospital	Elkton		Cecil
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Director		220-58-7035 1□ M 2X)F 48 Yrs.	Months Days Hours Min.	May 9, 195	9. Birthplace (State or Foreign Country) Maryland
	pug &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Aaryle f eho	ō		ake City		1 ☐ Yes 2 🛣 No
	28a-	rect	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	h with	Funeral Director	60 Leicester Way	21915	u.	SA
	deep	ner		 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo 	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	be ilied within 72 hours efter deeth with the Marylend tiel Hyglene. od other then "neturel; or items 23e or 28e-f ehow ovent, the Medical Examinat must be notified at event.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 9	1 ☐ Yes 2 No Specify:		Specify: White
00	hour	ed b	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b. I	Kind of Business/Industry
215	within 72 ene. then "ne	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work e. DO NOT use retired)		0.4 = 0.4
21	filed with Hyglene other the	Com	4 Ara	tist		elf-Employed
Maryland 21215-0036	be filed tel Hygk d other event,	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	
yla	thould by the Mante marked matic ev	٢	Evert Leon Dage 19a. Informant's Name/Relationship (Type, Print) 19b. Mi	ailing Address (Street and Number or Ru	len Linken	
Ma	d 2 sl th an th an 27 is r		7 7 7		apeake Cit	
	f Healitem		20b Place of Disposition	sposition (Name of		Location - City or Town, State
E	Pege net o int: If iry or		1 X Burial 2 □ Cremation 3 □ Removal from State Sphingwo Church (Specify)	remaiory or other place) ed Baptist emetery 09-1	7-2005 Spr	ingwood, Virginia
Baltimore,	permit. Peges 1 and 2 should be Dapartment of Health and Mante Important: If Item 27 is marked eny Injury or other traumatic e ance.		21. Sign the of Funeral Service Licensee	22. Name and Address of Facility R.T. 111 S. Queen Street		
			23a. Part1. Enter the disease, or complication / that cause 1 the death. Do not shock or heart failure. List only one cause 1 neach line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	i		Onset and Death
	/Medical		resulting in death) a Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	of breut		
-	led nslt	nine	cause. Enter Underlying Cause (Disease or injury	c Ca to bono	ad L	up
,	execun n and al-trai	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			4
68760	icate be executed physicien and s the burial-transit	edicai	a Distes o	neces		
_			IF FEMALE:			
Box	aath certifi ettending (for use es	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
<u>o</u> .	thet the da led by tha e detached t	ysic	1 Tes 2 No 4 Pregnant at time of oeath 9 Unknown	5 Other (specify)		
<u>α</u>	requires thet the daath certi een signed by the ettending hould be detached for use e		Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w requires been sign should be	ed by			1 ☐ Yes 2	2 No 3 Probably 4 □Unknown
Vital Records,	e faw re has bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	The ate h page	Com			performed? 1 ☐ Yes 2 Z N	death? lo 1 Tes 2 No
/ita	Physician: this cartific ral director,	Be	25. Was case referred to medical examiner?	Cher	th (Check only one)	
of	Physical dir	- To	1 Yes 2 Hospital: 1 atient 2 ER/Outpa 27. Manyler of Death 28a. Date of Injury 28b. Time	tient 3 DOA 4 Inursing h	ome 5 Residence 28d. Describe how inju	
	Attending I ir death. ector: After by the funer	tion	1 Natural 5 Pending (Month, Day Year) Injur 2 Accident investigation			•
Division	al or Attendi aftar death. I Director: A d in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	urs aft arel Di		Continue Observation To the base of the state of	anth annual at the time date and place	and due to the gaves	a) and manner as cloted
	To the Hospital or Atti within 24 hours aftar de To the Funarel Direct complataly filled in by ti	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, do not not not not not not not not not no	path occurred at the time, date and place r investigation, in my opinion, death occu	red at the time, date ar	nd place, and due to the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier	29c. License number DO4823	29d. D	ate signed (Month, Day, Year)
,			I Am Ceel Use MD			112103
_	8		30. Name and address of person who completed cause of death (Item 23a) (Ty)	3 West orach &	4, 8119	MJ 21921
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2 0 2005			

Lorinda Dauber

			1 - State Ragistrar	of Maryland		artment of H			giene Reg. 2 .005	31798
	Physici		1. Decedent's Name (First, Middle, Last)	41				2. Date of De.	ath 16	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and	number) LH	KE	4b. City, Town, or	Location of D	Death	4c. County of De	MICO
1	Funeral Director		5. Social Security Number 6. Sex 129-34-2858 125 M 2□ F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bird Min. (Month, Da April	9. E 25, 1938	sirthplace (State or Foreign Country) Maryland
\sim	show	J.	Usual Residence of Decedent 10a. State 10b. County MID Wicomico	10c. City,	Town or Lo	cation Salis	burv			10d. Inside City Limits 1 XYes 2 ☐ No
7	or 28e-f	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
7	eath w	erai [1402 Emerson Avenue 11. Marital Status 12. Was D	Decedent Ever in U.S.	. 13.	Was Decedent of Hi	21801		USA - 14. Race - Ar	nerican Indian,
920	urs after d ai', or iten Examiner	þ	1 Never Married 2 Married 1 Tys.	d Forces? es 2. Marion		fYes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, F Specify:	i? (Specify Yes or No Puerto Rican, etc.)		hite, etc. white
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or itema 23a or 28e-f show any injury or other traumatic event, the Madical Examinational be notified at Once.	Completed	15. Decedent's Education (Specify only highest grade complete	ed) ge (1-4or 5+)	(Ĝive life.	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most or)	f working	16b. Kind of Busine	
121	iled wil Hygien ther th nf, Ine	Con	12 17. Father's Name (First, Middle, Last)		t	ruck driv		Name (First, Middle,	freight	
Maryland	Mental Parked of	To Be	Wilbert S. Dean					lie Brambl	•	
Mar	d 2 shoth and the and the and the traum		19a. Informant's Name/Relationship (Type, Print) Sharon Dean	wife		_		or Rural Route Number Salisbury	er, City or Town, State MD 2180	_
altimore,	iges 1 an of Heal if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from	20b. Pla	ce of Dispo	sition (Name of matory or other place	e)	Date	20c. Location - City	
Baltim	ermit. Pa epartmer nportant ny injury nce.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Sali			s of Facility		Salisbury neral Home	P.A.
∞	20E = 9		23a, Part1. Enter the disease, or complications th	nat caused the death.	Do not ent			, Cambrid		613 Approximate
	Physician		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	ETASTATI	ic	LUNG	CAR	CINOMA		Interval Between Onset and Death
	/Medical Examiner		Due	to (or as a conseque	ence of):					
8760,	death certificate be executed eatlending physicien and dor use as the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a conseque						
687	ificate t g physical as the b	edica	d							
Вох		Physician/Medical	23b. Was decedent pregnant 1 Lin in the past 12 months?	, outcome of pregnand ive birth 2 □ Fetal d regnant at time of dea inknown	déath 3[Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
ds, P.O.	Se Ga	by	Part II. Other significant conditions contributing t	to death but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did t		to the cause of death? Probably 4 Unknown
Vital Records,	o _ c _ g	Completed							osy prior t rmed? death	autopsy findings available o completion of cause of ?
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		200	othe Othe	00	f Death (Check only o		pecify) HOSPICE
o	ding After fune	tion: To			R/Outpatier 28b. Time o Injury	f 28c. Injury Work	4 🗀 IAULSI		now injury occurred	becity) 1103/1-12
Division	i or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be 28e. P	lace of Injury - At horn uilding, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel of within 24 hours a To the Funeral Completely filled in	edical C	29a. Certifier Certifying Physician: To (Check only one)							
	within 3	Med	29b. Signature and title of certifier	Tarrior orange.		29c. License	number		29d. Date signed (Mo	
}			18ku v	nn			5841	10	9-17-	05
			30. Name and address of person who completed of HULAM WAR (S	26266	23a) (Туре, АРР	Print) OWWOD	CT.	SAVIS	BURY	mo: 2/80/
	Sta Regist		31. Date filed (Month, Day, Year) 3 SEP 1 9 2005	2. Registrat's Signatu	J.	Sports				

			for State	State of I	Marylan	•	artment of H			•	giene Rog. No	005	21700
			Registrar 1. Decedent's Name (First, Middle	o, Last)			incate or	Death		2. Date of Dea	ath	UUJ	3. Time of Death
	Physici		Lawrence	Aloysi	ıs	D	ignan			Septem	-berl	6, 200	5-02:50AM
	/Medio Examir		4a. Facility Name (If not institution				4b. City, Town, o	or Location of	of Death			ounty of Deat	
			l Glenwood S				Earlev					ecil	
	Funeral		5. Social Security Number	6. Sex 7.		last birthday). Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birt (Month, Da	th y, Year)	Co	thplace (State or Foreign puntry)
	Director		221-24-0212 Usual Residence of Decedent		66					Jun 2	9,19	39 W1	<u>lmington</u> D
	within 72 hours after death with the Maryland ane. than "natural", or Itams 23s or 28s-f show he Mcdical Examiner must be notified at		10a. State 10b. County	11	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	a-fsh	ctor	MD Cec	il		Earle	ville						1 ☐ Yes 2 🖾 No
	ith the	Director	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Co	ountry?
	ath w		l Glenwood St				2191				1	USA	
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Ori an, Mexican	igin? (Spec 1, Puerto P	cify Yes or No- Rican, etc.)	- 14	Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 📉 Yes 2 If Yes, Give Year or Date		1	☐ Yes 2X No	Specify:			S	pecify:	White
9	2 hou atura	ted	15. Decedent	's Education		16a. Deced	lent's Usual Occup	pation			16b. Kind	of Business/	/Industry
215	thin 7 B. Bn "n Med	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	kind of work done OO NOT use retire	nd)		ng			
2	filed wii Hygien othar th	Con	12				Plant W	T				hemic	al
nd	be filed tal Hygie d other event,	Be	17. Father's Name (First, Middle,					100		(First, Middle,		ı <i>ma</i> me)	
3	2 should be a and Mental I is marked or raumatic eva	T ₀	William France 19a. Informant's Name/Relations		า	10h Mailin	g Address (Street			Snyd		Four State	7in Codo)
Maryland 21215-0036	20 E M ==				2		enwood						
	Health tam 27 other tr		Marie Elizabe 20a. Method of Disposition	eth Dignal	20b. F	lace of Dispos	sition (Name of			ate		ation - City or	
JO L	ages ent of nt: ff i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		i An	atomy	Gift		9/16	/05	Hano	ver,	Maryland
Baltimore,	permit. Pages 1 and Department of Healt Important: if itam 2 any Injury or other 2008.		21. Signature of Funeral Service			egist 10442	Y Name and Addre	ess of Facilit	ty Be	eson	Fune	ral H	
			23a. Part1. Enter the disease, or	complications that cau-	sed the deat	h. Do not ente						., 55	Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final										Onset and Death
	/Medical	Ġ	disease or condition resulting in death)	Due to (or	as a conseq	uence of):	wer						6 months
	Examiner		Conventially list conditions	b. ————									
	ם יו	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a conseq	uence of):							
	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):							
8760,	be ex icien burial		,	000 10 (0.	45 4 50/1004	d01100 01).							
687	death certificate be executed e attending physicien and of for use as the burial-transit	edical		d									
Box (eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							230	d. Date of del	ivery
	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth	t at time of d		Ectopic pregnanc Other (specify) _	У				Month	Day Year
P.0.	t the by th ache	hys	9 Unknown	9□ Unknow	1					1			
Ś	se und	by F	Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the ur	nderlying cause giv	ven in Part I.	•				the cause of death?
ord	w requires been sign should be	ted								1 A (Y	/es 2 □ I	No 3∏Pr	obably 4 Unknown
of Vital Record	S S S	Completed								24a. Was autop		24b. Were au prior to death?	topsy findings available completion of cause of
a F	T age									1 Yes	2 No		2 □ No
Z.	Physician: The this certificate ral director, pag) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 💆 No	Hospital:	-tit 2 🗆	ED/Out	Ott	nor.		(Check only o		7045 (0	-7.1
oţ	Phys r this aral di	To :	1 ☐ Yes 2/A No 27. Manner of Death	28a. Date of I (Month,		ER/Outpatient 28b. Time of	28c. Inju	ry at		ne 5 Resid			city)
lon	Attending ir death. actor: After by the fune	tlor	1 (ANatural 5 ☐ Pendin 2 ☐ Accident investig	3	Day Year)	Injury	M 1	rk?]Yes 2 ∐1	No				
Division	Attendi r death. actor: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could in determine	ined 286. Place of	Injury - At he	ome, farm, stre	eet, factory, office		2	8f. Location (S City or Tow		Vumber or RL	ural Route Number,
ā	s after al Dira	Certification;	4 1 Hornicide	building,	etc. (Specii	y)					ni, Otato)		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the be Examiner: On the basi and manner	s of examina	wiedge, death tion and/or inv	occurred at the ti restigation, in my o	me, date an opinion, dea	id place, ai th occurre	nd due to the o d at the time, o	cause(s) an date and pl	nd manner as lace, and due	stated. to the cause(s)
	To the h within 24 To the F complete	Me	29b. Signature and title of certified	10 1			29c. Licens	se number			29d. Date s	signed (Monti	h, Day, Year)
			▶ <i>U</i> ₁	fork	01,/	1)	115	314	£		Sept.	ember	16,2005
	OTIVA		30. Name and address of person	who completed cause of	1	n 23a) (Type, I	Print) Che	supreh	le It's	Nice E	= 1/20	n, M	16, 2005 D
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 20	32. Reg	strar's Signa	Apart	W.						

			1 - For Stete Registrer	State of	Marylar		artmen rtificate			and M	-	giéne Reg. N2	005	318	0.0
J.	Physici		Decedent's Name (First, Middle, Lass Betty Jane D								2. Date of De Month September	ath Day	Year ACOS	3. Time of	Death A M
)	/Medi Examir		4a. Facility Name (If not institution, give Washington Count	street and numb					Location o	of Death	Sepreme		County of Death		
	Funeral Director		1/4-20-8505	9x 7. □M 2[X]F	Age (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 9	th y, Year) ,1926		place (State ontry)	r Foreigi
	e Maryland 3e-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Washing	gton	10c. Ci	ity, Town or Lo								10d. Inside Ci	
	with th	Dire	10e. Street and Number 14565 Pennersvill	e Rđ			10f. Zip		719			10g. Citiz	en of What Coul	ntry?	
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 is marked other than "natural; or itame 23a or 28a-f show other traumatic event, the Modical Examinational be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X i No		Was Deced f Yes, spec	ent of Hi		gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White,		:e
121215-0036	iled within 72 h tygiene. ther than "natu nt, its Medica	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 3		or 5+)		dent's Usua kind of woi DO NOT us OMEMA	rk doné a se retired,	luring mos.		ng (First, Middle		d of Business/In	•	
Maryland	2 should be filed within and Mental Hygiene. is marked other than "sumatic event, the Mon	To Be	John V. Alexan 19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address	(Street a	L:	illie	⊋ V. Co	oper	oumame) Town, State, Zip	Code)	
	s 1 and 2 of Health a item 27 is other train		Clarence J. Dingle 20a. Method of Disposition		20b. l	14565 Place of Dispo			-1	0	Cascad		21719 ation - City or To	own, State	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	')	area	ethel C		ry		Sept. 2005	5		scade,Md Bradbury		
68760, <	Physician /Medical Examiner physician and he prinal-Iransit	edical Examiner	shock, or heart failure. List only in shock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a consect	quence of):	er the mod	e of dying	g, such as	cardiac c	or respiratory a	rrest,	earl	Approximation and Interval Betto Onset and I	ween
P.O. Box	wrequires that the death certifica been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	h 2 ∏ Feta nt at time of d n	al death 3 death 5	Ectopic pr Other (sp	ecify)					3d. Date of delive Month	Day Y	'ear
	requires the	Completed by	Part II. Other significant conditions or	ontribuling to deal	dir but not res	sulting in the u	nderlying c	use give	Pen in Part 1.	un		obacco us Yes 2 🛂	No 3 Prot	ne cause of di pably 4 🗀 U	
tal Rec	en: The law lificete hes b or, page 2 s	0	25. Was case referred to medical						OS Diago	of Dooth	1 ☐ Yes	osy irmed? 2 1 No	24b. Were auto prior to co death? 1 Yes	psy findings a mpletion of ca 2 No	available ause of
of Vi	hysicie his cert il direct	8	examiner? 1 □ Yes 2 □ No] ER/Outpatier			^{PC} 4□Nu		n <i>Check only o</i>		□Other (Specif	y)	
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	27. Mann of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of		28b. Time of Injury	М		at ? ∕es 2 □	No	28d. Describe 28f. Location (. City or To	Street and	occurred Number or Rura	tl Route Numi	ber,
	To the Hospital within 24 hours a To the Funeral to completely filled	Medical Co	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the basiner: On the bas	is of examina	owledge, death ation and/or in	occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner as s place, and due to	tated. the cause(s))
	To th within To th compl	Me		completed cause	of death (Ite		Print)	License	220	0		9/2	signed (Month,	Day, Year)	
DH	Sta Regist		31. Date filed (Month, Day, Year) SEP 3 0 2	175.0	istrar's Sign		irsn	1B	LVD	JM	ITW6	16-	MD	2178	33

State of Maryland / Department of Health and Mental Hygieho0 ho5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 22, **Physician** Υ_θаг 2005 Dickerhoof Constance 2340 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 17, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 ☑ F Yrs. 214-07-0948 93 **Director** Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner norst be notified at MD Allegany Cumberland Funeral Director ty∑Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 10 North Liberty Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: white Be Completed by 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 banding dept. tire co. . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 Is marked other t jury or other traumatic event, it. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Porter W. Goff Cora (Ryan) Goff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Phillippi granddaug P.O. Box 571 Oakland MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 9/26/2005 Cumberland Sunset Memorial Park MD* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT 12 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 🗷 No 3 Probably 4 MUnknown Completed en: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 2 No 1 Yes Physician: : After this certification of the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? To the Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) twee 4 SEPTEMBER 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ROBUSTIANO BARRERA, 500 MEMORIAL AVE. CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 9 2005 Registrar

			For State Registrar			Depa	artment of F	lealth a	and Mer	ntal Hyg	_		180	12
			Registrar Decedent's Name (First, Mid	dle, Last)		Cer	uncate or	Dealii		Date of Deat			3. Time of E	
	Physicia		Annie E.									Year	2:40	
	/Medic Examin		4a. Facility Name (If not instituti				4b. City, Town, o	or Location o			4c. County of		2.10	P
			Frostburg '	Village Nur	sing F	Home	Frost	burg			Alle	gany		
	Funeral Director		5. Social Security Number 215-44-8900	6. Sex 1 ☐ M 2 ☑ F	ge (In yrs. last b	yrs.	If Under 1 Year Months Days	If Under:	Min. Ma	Date of Birth (Month, Day, Y 26,	^{Year)} 923	9. Birthplace Country) V1r	e (State or ginia	Foreign a
	land		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, To	wn or Lo	cation					10d.	Inside City	Limits
	Mary -f sh	ţ	MD Alle	egany	Fros	stbu	rg					}	1 Yes	2 🗌 No
	th the or 28s	lrec	10e. Street and Number			-	10f. Zip Code			10	g. Citizen of W	hat Country	?	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Madical Exama actment by modified at	by Funeral Director	156 E. Mai	in Street			215	32			USA			
	er deg	nne	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decedent of H f Yes, specify Cub	dispanic Orig an, Mexican	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)		- American , White, etc.		
36	Ir, or	by F	1 Never Married 2 Ma 3 XWidowed 4 Divorce	If Yes Give			1□Yes 2√∑No	Specify:			Specify:	Wł	hite	
21215-0036	2 hou	ted	15. Deced	ent's Education		a. Dece	dent's Usual Occup	oation			16b. Kind of Bus			
215	thin 7	Completed	Elementary/Secondary (0-12	nest grade completed) College (1-4or	5+)		kind of work done OO NOT use retire		t of working					
121	led w lygier her th		12 17. Father's Name (First, Middle	n (oot)		НО	memaker				Home			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 23s or 28s-f show Important: If them 27 is marked other than "natural", or thems 23s or 28s-f show any injury or other traumatic event, the Medical Exams at must be multified at once.	o Be	Robert Heiske						th Sc		Maiden Sumame	P)		
ary	shou and M is mar	1-	19a. Informant's Name/Relation		19	9b. Mailir	g Address (Street	and Numbe	er or Rural Ro	oute Number,	City or Town, S	State, Zip Co	de)	
∑ ()	and 2 lealth m 27 her tri			ixon So			E. Main			-				
Baltimore,	ages 1 or of H or ot			n 3 □Removal from State			sition (Name of natory or other pla		Date		20c. Location - 0			
Ħ	artmer artmer ortant injury		4 □ Donation 5 □ Other21. Signature of Funeral Service		pavis		morial . Name and Addre							
Ba	permi Depa Impo any in		Form S	. Holer,	TH.	1	302 Nat	iona	l Hwy	., La		MD 2	21502	2
P			23a. Part1 Enter the disease, shock, or heart failure. Immediate Cause (Final			A	An A		cardiac or re	spiratory arre	st,	Int	proximate erval Betwo set and De	een
	Physician /Medical		disease or condition resulting in death)	α.	WN Geo		Dement	ia.				:	2 year.	25
	Examiner				s a consequence	e 01).								
V	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	э а сопзециейс	e or).								
•	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequenci	a af):								
8760,	icate be executed physician and s the burial-transit	cal E	,	Due to (01 as	s a consequence	e oi).								
9	ifficate g physas the	B		d						-				
Вох	eath certific attending p I for use as i	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal dear	th 3	Ectopic pregnanc	v				of delivery		
	the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 💢 No 9 ☐ Unknown		at time of death		Other (specify)	,			Mon	th Day	y Ye	ear
P.0	that the de ed by the detached		Part II. Other significant condi	itions contributing to death	but not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use contril	oute to the c	ause of de	ath?
Records,	taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ed by										3 ☐ Probably		
ecc	e law re has be je 2 sh	Completed								24a. Was ar		ere autopsy ior to comple	findings av	vailable
<u>=</u>	th ate pag	Con								perform	ed,? de	eath?	K No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:			. 20 pos Ott		of Death Ch					
of	Phys	To To	1 ☐ Yes 2 ▼ No 27. Manner of Death	28a. Date of Inj	ient 2 ☐ ER/C	Outpatien Time of	1 3 DOA	4 Nu			nce 6 Other			
ion	Attending Phy r death. ector: After thii by the funeral o	atlor	Natural 5 Pend 2 Accident inves		ay Year)	Injury	28c. Injur Wor M 1	rk? Yes 2⊟1			,,			
Division	r Atte	ertification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 280. Place of Ir	njury · At home,	farm, str	eet, factory, office		28f.	Location (Str City or Town	eet and Numbe. State)	r or Rural Ro	oute Numbe	e <i>r</i> ,
Q	urs aff eral Di	O	3.7						14:					
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 X Certify (Check only one) 2 Medic	ving Physician: To the bes al Examiner: On the basis and manner s	of examination a	ge, death and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and the occurred a	due to the ca t the time, da	use(s) and man te and place, ar	ner as stated nd due to the	d. e cause(s)	
	To the comp	W	29b. Signature and title of certification	. 0 0 0 .			29c. Licens			29	d. Date signed	(Month, Day	, Year)	
•			worker	10000	MD			055	325		Sep 23	,200	5	
_	Ģ		30. Name and address of person WONSOCK SH	IN MD 4	8 Town	Te	Print)	Fros	stbw	eg M	10215	32		
	Sta Registr		31. Date filed (Month, Day, Yes	2005 . Regist	trar's Signature	Con	E)			0				

State of Maryland / Department of Health and Mental Hygiena 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 12, 2005 11:18 A M **Physician** Ruth ELKINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Year) | 9. Birmplace (Month, Day, Month, Day, Year) | 9. Birmplace (Month, Day, Month Montgomery Suburban Hospital 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2₽F Yrs. Director 064-01-7479 Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 17 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the Madical Exeminar must be notified at 1 ☐ Yes 2√∑ No Director Greenbelt Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 United States 14G Hillside Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Internal Revenue Elementary/Secondary (0-12) College (1-4or 5+) Statistical Assistant Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Leon Winkelstein Masha JOTE, M.
Jermit. Pages 1 and 2 sho.
Department of Health of Important: if there any injury of page. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14G Hillside Road, Greenbelt, MD 20770 19a. Informant's Name/Relationship (Type, Print) Benjamin Elkins, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 09/15/05 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens Olney, MU 21. Signature of Juneral Service Licenses Torchinsky Hebrew Funeral Home 1 254 Carroll St., Nw. Washington, DC 20012 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hoepital or Attending Phyelcien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sepsis 4 Unknown 1 Yes 2 No 3 Probably Fibrillation Atrial 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 20 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54776 05 Energerly Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD Blair Leonard, 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 1 5 2005 Registrar

mend-Unpend Type or Print in Black Indelible link. Ensure All Copies Are Legible.

LPH	ERVIN		Amend-Unpend	State of					lental Hy	giene	0.05	01001
			For State Registrar 1. Decedent's Name (First, Middle,	f not)	Ce	ertificate	of Dea	nth	2. Date of De	Reg. No.	005	3 8 4 3. Time of Death
ı	Physici		Ralph Coleman Er						Month SEPT.	Day	2005	1005 A M
	/Medic Examin	er	4a. Facility Name (If not institution, UNIVERSITY HO	give street and numb SPITAL	oer)	4b. City, Tov BALT	vn, or Locat IMORE		DILL.	4c. C	ounty of Death	1
2	Funeral Director		5. Social Security Number 345-42-4692	5. Sex 7. 1X M 2 ☐ F	Age (In yrs. last birthda 57 Yrs.	/) If Under 1 Y Months Do	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da 09/08/	th ly, Year)	9. Birth	nplace (State or Foreign untry)
ý			Usuel Residence of Decedent		10.00				09/00/	1940		OK
	ith the Marylan or 28a-f show	ō	MD Washir	ngton	10c. City, Town or Hagerst							10d. Inside City Limits 1
	or 28a-	Irect	10e. Street and Number		11080100	10f. Zip Co				-	n of What Co	untry?
	ath wit	ralD	136 East Avenue			2174				U		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other then "naturel", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be maillied at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedor Armed Force d 1 Tes 2 If Yes, Give Year or Date	XNo	. Was Decedent If Yes, specify 1 ☐ Yes 2 ☑		c Origin? (Spe xican, Puerto ecify:	ecify Yes or No Rican, etc.)		Black, White	
2-0	72 ho	eted	15. Decedent's (Specify only highest		16a. Dec	edent's Usual O re kind of work d DO NOT use re	ccupation one during	most of worki	ing	16b. Kind	of Business/I	ndustry
21215-0036	iene. rthen	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Labo				C	onstru	ction
	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, L.						e (First, Middle,		umame)	
Maryland	d Men marke matic	2	Booker T. Ervin,		19h Ma	iling Address (St			ae Morr		Town State 7	in Code)
	and 2 s alth an 27 io		Elaine Ashkettle			East Ave						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Baltimore,	Pages 1 and of He Int: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	9-20-	2005 72005		ation - City or 1					
Balt	## Donation 5 Other (Specify) Rose Hill Cemetery 07/20/2005 Harerstown 22. Name and Address of Facility Gerald N. Minnich Francisco 305 N. Potomac Street, Hagerstown 305 N. Potomac Street, Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street Hagerstown 305 N. Potomac Street 305 N. Po											neral Home
8760,	Physician be executed with a supplication and so as the burial-transit	Ilcal Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to (or b. Due to (or	ras a consequence of): ras a consequence of):	Cardiova	ascula	ar Dise	ease			Interval Between Onset and Death
P.O. Box 6	requires that the death certific: een signed by the ettending pl nould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birt	nt at time of death	B⊟Ectopic pregr B⊟ Other (specif				23	d. Date of deli Month	very Day Year
	ires that signed b	by P	Part II. Other significant condition			underlying caus	e given in F	Part I.		obacco use		the cause of death?
cor	> 0 0	letec	Adult Polycysti End Stage Renal		visease;				24a. Was			
Vital Records,	The ete h page	e Completed by	Status Post Rei		lant				1 Yes	ormed? 2□No	prior to death?	topsy findings available completion of cause of
-	S S D	To Be	examiner?	Hospital: 1 🗆 In	patient 2 X ER/Outpat	ent 3 DOA	Other		h <i>(Ch</i> eck o <i>nly d</i> me 5⊟Resi		☐Other (Spec	cify)
on of	ling Ph		27. Manner of Death 1 Natural 5 □ Pending		Injury 28b. Time Day Year) Injury		Injury at Work?		28d. Describe	how injury	occurred	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident investigi 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place o	of Injury - At home, farm, g, etc. (Specify)	M street, factory, of	1 ☐ Yes ffice		28f. Location (City or To	Street and wn, State)	Number or Ru	iral Route Number,
	he Hospite n 24 hours ne Funerei sletely filler	Medical C	Check only one) Certifier Check only one)	Physician: To the bas xaminer: On the bas and manne	set of my knowledge de sis of examination and/or or stated.	ath occurred at t investigation, in	he time 3a my opinion	te and place , death occur	and due to the red at the time,	date and p	nd manner se lace, and due	ttated to the cause(s)
	within To the	Ě	29b. Signature and title of certifier		2m.	29c. L	icense num				signed (Monti	,
;	75		30 Name and address of person v	the completed area	of death (Item 222) (Time	e Priot)	O.C.1	1.E		SEP.	r. 15,	2005
	U		PATRICIA Ar	onica-tol	AK 111 PE	NN STREE	ET, BA	ALTIMOF	RE,MARYI	LAND 2	21201	
	St Regist	ate rar	31. Date filed (Monith, Day, Year)	2005 32.7	gistrar's Signature	hards						
	, legist		OLI 20		ELE N. P	10						

			1- State Amend#19b pe Registrar Unpend Item	State of Marylaner fh 09-27-2 23a,pt.II,27	d / Depa 005 cn per Ce	artme Tifica	nt of H	ealth a Death	e G84			5	3180	
	Physici /Media		1. Decedent's Name (First, Middle, Last) CALVIN H	ARVEY F	ITZ.	JI	٧,			2. Date of De Month SEPTEN	^{Day} 1BER 20,2	Year 005	3. Time of De 8:40A.	ath M
>	Examir		4a. Facility Name (If not institution, give st FREDERICK MEMORIAL	reet and number)		4b. Cit		Location of	f Death		4c. County of FREDE	f Death		
	Funeral Director		45-46-0000	7. Age (In yrs. 56	last birthday) Yrs.		er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir Month, Day July 8	th. 1949 W	9. Birthp Coun /ASM	lace (State or F	oreign DC
	with the Maryland a or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Frederi	1	y, Town or Lo	ville				,			0d. Inside City t	
	th with ti	al Dire	10e. Street and Number 5221 MUIRFI	ELD DRIV	'E	10f. Z	ip Code 21	754	ļ		10g. Citizen of W		try?	
250	hours after dea turel', or items	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Pres 2 No Pres, Give Year or Dates:			edent of Hi ecify Cuba 212 No	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	ofy Yes or No Rican, etc.)	14. Race Black Specify:	, White,	etc.	
N-C1717	f within 72 hou liene r then "nature the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	life.	kind of v DO NOT	vork done o use retired	luring most		g	16b. Kind of Bus 50410 DISPO	WI	9556	
ylana ,	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) CALVIN H. FIT					LEO	NA	PEN.	Maiden Sumame	r)		
Mar	ind 2 shi alth and 27 is m		19a. Informant's Name/Relationship (Typ BRENDA M. F	e, Print) FITZ (WIFE)							er, City or Town, S			754
TOLE,	Pages 1 a ent of He nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disponentery, crea	sition (N	ame of other place	9)	Da	ate	20c. Location - C	ity or To	wn, State	
Dall	Departm Departm Importar eny inju		21. Signature of Funeral Service Lice de De De De De De De De De De De De De De		E	Name AR	and Addres	SOUTH	NS ST	FILE	MAL HOM DERICK,	MD	2170	21
8/60,	iate be executed hysicien and live builatiransit into builatiransit in	dical Examiner	resulting in death)	Due to (or as a conseq	uence of):							LOMYC	Approximate Interval Betwee Onset and Dea Deathy	
O. BOX 6	the death certificate y the attending physi ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	∃Ectopic ∃ Other (pregnancy specify)				23d. Date Mont		ry Day Yea	r
rds, P	requires that the der reen signed by the a hould be deteched f	Ď	Part II. Other significant conditions condit					en in Part I.			obacco use contril		e cause of deat	
Vital Records	The law ete has b page 2 s	Completed							_		psy pr ormed? de	or to con ath?	osy findings ava npletion of caus 2 No	ilable e of
	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1X Yes 2 No	ospital: 1 ☐ Inpatient 2 🛣	ER/Outpatier	nt 3 🗆 🛭	Othe Othe	·-		Check only one 5 □ Resi	one) dence 6 ⊡Othe	(Specify	·)	
lon of	fe fe		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time or Injury	f M	28c. Injury Work 1 🔲		2		how injury occurre			
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	reet, facio	ory, office		2	8f. Location (City or To	Street and Number wn, State)	r or Rurai	Route Number	
	e Hospi 24 hou s Funer letely fill	Medical	29a. Certifier 1 Certifying Physical Check only one)	er: On the basis of examina and manner stated.	wladga, deat ition and/or in	vestigation	d at the tar in, in my op	e, data and inion, deat	d plana la h occurre	nd due to the d at the time,	causa(s) and man date and place, ar	or as sto	the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	2/, 0.		2	9c. License	ME			29d. Date signed	(Month, L	Day, Year)	
1		1	30. Name and address of person who con	mpleted bus of death (Item	n 23a) (Type,	Print)	Donn	Stroo	+ D.		SEPTEMBER			
			THE ODONE MIEM	32. Resistrar's Signa	ture			orree	L B	ат с IIIIO.	re, Maryl	DIID	21201	
	Sta Regist		SEP 2 7	OUD Flower	J. A	bou	2							

	307						. Ensure All			
aro	d Augus	st :	Fogtman Amend Item	8State of Ma	aryland / Depa	artment of I	Health and Me	ental Hygiei	POOF	01000
			1 - State Registrar WCHD/SH 9/	22/05 per	FH Ce	rtificate of	Death	Reg.	Z 1 1 1 1 . 1	31806
	Physici	an	1. Decedent's Name (First, Middle, La	•			2	2. Date of Death Month	Day Year	3. Time of Death
	/Media		Edward August					September	14,2005	17:45 P M
1	Examir	ner	4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death		4c. County of Deat	
			16460 Heather Ric 5. Social Security Number 6. S		e (In yrs. last birthday)	Hagerst	OWN	V	lashington	n
	Funeral Director			iXim 2□F	51 Yrs.	Months Days	Hours Min.	Month, Day, Ye	7 2 3 / 3 39. Birth	hplace (State or Foreign untry)
			217-48-3119 Usual Residence of Decedent			<u> </u>	1	(OV 25 T	223 1.10	aryland
	how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	sa-f-	cto	Maryland Washin	gton	Hage	rstown				1 ☐ Yes 2½ No
	ith th	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	hours after deeth with the Maryland turel', or Iteme 23a or 28a-f ehow al Exeminar must be notified at		16460 Heather				21740	U	nited Sta	
	item item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
36	irs aft	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X 1 If Yes, Give Year or Dates:	NO	1□ Yes 2XNo	Specify:		Specify: Wh	nite
21215-0036	72 hours natural', dical Ex	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Dccu	pation	16b	. Kind of Business/	Industry
215	l within 72 ho liene. r then "natur the Medical	Pe e	(Specify only highest grant (0-12)	a <i>de completed)</i> College (1-4or 5	5+) (Give	DO NOT use retire	during most of working ad)	7		
7		Completed		4	R	egistered	1 Sanitaria		County Go	vernment
pu	be filed Ital Hyg of other	Be	17. Father's Name (First, Middle, Last				18. Mother's Name (First, Middle, Maid	len Sumame)	
Maryland	d 2 should be th and Mental 7 is marked o traumatic eve	ို	George L. Fogtm 19a. Informant's Name/Relationship	The second secon	105 14-11	and Address (Cons.)			rrison Fo	
Mai	12 E		Beverly Delleen	• • • • • • • • • • • • • • • • • • • •			tand Number or Rural I er Ridge Rd			. ,
	Head H		20a. Method of Disposition	rogulari (w	20b. Place of Dispo	osition (Name of	Dat		Location - City or	
ğ	0 0		1 the Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Speci		1	matory or other pla	Cem, 9-17-	05 11	ogovator m	Maryland
Baltimore,	permit. Pag Depertment Importent: I eny Injury o		21. Signature of Funeral Service Lice	· · · · · · · · · · · · · · · · · · ·			ess of Facility Doug		agerstowi.	1 Trans
ä	Den in per		// Junoton C.	& Tin	4 1	331 Faste	ern Biva. N	Hagers	tery rune	ral Home
			2 a. Part1. Enter the disease, or come shock, or heart failure. List only	plications hat cause	the death. Do not en				COMIT TRALLY	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	One cause on each	antred	Trad	Ation.	1011	0-0	Onset and Death
7	/Medical		resulting in death)	Due to (or as	a consequence of):	00431	of Cour		rand	
	Examiner		Sequentially list conditions	b						
	ם ב	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	be executed siclen and burial-transit	Examine	that initiated events resulting in death) Last	C. Due to /or as	a concessioned of					
60,	clen burial			Due to (or as	a consequence of):					
687	death certificate b e attending physic id for use as the b	Physician/Medical		d						
×	nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of deli	vog.
Вох	atter d for u	clar	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	ey		Month Month	Day Year
0	at the de by the tached	hysi	9 Unknown	9□ Unknown						
s, P	The law requires that the ste hes been signed by th bage 2 should be detache	by P	Part II. Other significant conditions	contributing to death b	out not resulting in the u	underlying cause gr	ven in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
ğ	v require been sig should b	edt						1 🗆 Yes	2 No 3 Pro	obably 4 DUnknown
၁၁	e law re hes bed je 2 sho	plet						24a. Was an	24b. Were au	topsy findings available
Ä		Completed						autopsy performed Yes 2	? \@ay\?	completion of cause of
/ita	ician: Th certificete ector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death (1	/	
of Vital Record	Physician: r this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inpatie		III JUDOA	her: 4 Nursing Home		6 ☐Other (Spec	cify)
	e fe	on:	27. Manner of Death 1 ☐ Naturat 5 ☐ Pending	28a. Date of Inju	lry Year) 28b. Time of Injury	Wo		d. Describe how in	njury occurred	-11
Division	Attending in deeth.	27. Manner of Death 1 Naturat 2 Accident 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28a. Date of Injury 3 Year) 28b. Time of linjury 4 Work? 4 Nore of Death 1 Naturat 5 Pending investigation 6 Could not be determined 28a. Date of Injury 4 Nore? 28b. Time of linjury 8 Work? 1 1 Yes 2 Invo 28f. Locatic City or City or							40001	selo
Σ	after after Direction by	ertif	4 Homicide determined	building, et	ic. (Specify)	reet, ractory, office	/		and Number or Ru ate)	ral Route Number,
_	To the Hospital or Attendi within 24 hours after deeth. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 ☐ Certifying P	hysician: To the best	of my knowledge, dea	th occurred at the ti	ime, date and place, an	d due to the cause	e(s) and manner as	stated 21749
	Ho Ho Fur letely	edical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examination and/or in	nvestigation, in my	opinion, death occurred	at the time, date	and place, and due	to the cause(s)
	withir To th comp	Ž	29b. Signature and title of certifier	\wedge		29c. Licen	se number	29d.	Date signed (Month	n, Dey, Year)
	1.		I Lalo.	M)		O.C.M	M.E.	Ser	otember 1	5, 2005
	S		30. Name and address of person who	completed cause of	death (Item 23a) (Type	, Print)				
	75		Juthon w	re my	111 Penn	Street,	Baltimore,	Maryland	1 21201	
		ate	SEP 20	2005 32. Registr	rar's Signature	perle				-
	Regist	ar	JLI ~ U							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. () () 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1800 seymour Fielden tog well 12,2005 September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grave Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 22, 1 Rockvile montg omery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State
Country) **Funeral** 1**⊠** M 2□ F 79 Ĩ926 020-20-1941 Massachusetts Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ?7 is marked other than "neturel", or Items 23a or 28e-f show traumatic event, the Medical Examinar must be multiped at 1 TyYes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with #311 8 Russell Avenue, 20877 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. In figure 27 is marked other than "neturel", or flem any injury or other traumatic event, the Medical Evantment on the 1 ☐ Never Married 2 ☑ Married 1 SYes 2 No 1944− If Yes, Give Year or Dates: 1946 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1946 White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Federal College (1-4or 5+) Elementary/Secondary (0-12) Economic Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard E. Fogwell Mabel E. Fielden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther M.C. Fogwell/ Wife 8 Russell Avenue, #311, Gaithersburg, MD 20877 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place)
Parklawn September 1 😾 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 17, 2005 Memorial Park Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home, ature of Funeral Service Licenses 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4days **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year Month 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Parlanson's Disease 2 No 3 Probably 4 Unknown 1 Tyes Completed Sacral Decubitus 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe mea? 2 **N**o 2 🗆 No 1 Yes 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No P 1 XInpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M 2 Accident within 24 hours after death

To the Funeral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Priscilla Collabar Lyon 041794 Spotember 12 2005 MO +1 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priscilla Callatan-Lyon mo 911 Russell Avenue Gaithersburg, MD 20879 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 15 2005 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie [] 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Fredericks September 14, 2005 5:30 Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6121 Mountaindale Road Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 6. Sex **Funeral** Days Hours 1 ☐ M 2 🖾 F Months Min. 24, 1910 Pennsylvania 95 Mar. Director 201-10-3838 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "netural", or Items 23e or 28e-f show New 1 XYes 2 ☐ No Director Glendora Jersey Camden 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 606 Evesham Road 08029 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Pages 1 and 2 should be filed in the part of Health and Mental Hygic out; If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna McGovern Patrick McHale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Fredericks/ Granddaughter 6121 Mountaindale Road Thurmont, Maryland 21788 other 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State September 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Chewslanding, injury or permit. Page Department of Importent: If eny injury or once. *4 □Donation 5 □ Other (Specify) Joseph's Cemetery 2005 New Jersey 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final **Physician** Alzheimers Dementia with Failure to Thrive Years disease or condition resulting in death) /Medical **Examiner** Advanced Osteoporosis with Scoliosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Osteoarthritis Years attending physician and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☒ No be detached the of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mobility Disorder, Glaucoma 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 1 Yes 1 ☐ Yes 2X No 2 X No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Granddaughter's 6 MOther (Specify)Residence Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending njury 1 XNatural after death. 1 Yes 2 No investigation 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitel within 24 hours To the Funeral 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the Ž 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year)

Registra

State

Toll House Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

801

32. Floistrar's Signature

Allen Rielly,

D45749

September 14, 2005

Frederick, Maryland 21701

			For Stata Registrar	State of Marylan		urtment of Health tificate of Deat		giene	5 31809					
	Physici /Medic Examin	al	Decedent's Name (First, Middle, LETT) 4a. Facility Name (If not institution, g		Gu	TIERREZ 4b. City, Town, or Location	2. Date of De Month	Day	Year 2005 11 38 A M					
	Funeral Director		3304 Ward Klin		last birthday) Yrs.	Myersy if Under 1 Year If Under 1 Year Hours	er 24 Hrs. 8. Date of Bi	rth ay, Year)	Frederick 9. Birthplace (State or Foreign Country) West Virginia					
	he Maryland 28a-f show cuiffed at	ector	10a. State 10b. County Maryland Free	derick 10c. Cit	y, Town or Lo	Myersville			10d. Inside City Limits 1 ☐ Yes 2 ☐ X\00					
036	d within 72 hours after death with the Maryland jene. r then "netural", or Items 23a or 28a-f show the Mudical Exama or must be invilled at	by Funeral Director	10e. Street and Number 3304 Ward Kline 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?		10f. Zip Code 217 Vas Decedent of Hispanic C Yes, specify Cuban, Mexic	Origin? (Specify Yes or Nan, Puerto Rican, etc.)	10g. Citizen of 14. Rac Bla Specif	USA ce - American Indian, ck, White, etc.					
21215-0036	d within jiene. r then	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education prade completed) College (1-4or 5+)	(Give	lent's Usual Occupation kind of work done during mo DO NOT use retired) Teacher	ost of working	16b. Kind of B	usiness/Industry Education					
Maryland 2	s 1 and 2 should be filed f Health and Mental Hygi item 27 Is marked other other treumatic event, [To Be C	17. Father's Name (First, Middle, La Virgil Macket 19a. Informant's Name/Relationship	ey	19b. Mailin			andergri	ne) f †					
altimore, Ma			Maggie Gutierre 20a. Method of Disposition 1 & Burial 2 Cremation 3 4 Donation 5 Other (Spe	ez - Daughter Carry	3304 Place of Dispo	Ward Kline R sition (Name of natory or other place)	d. Myersvil	le, Mary I	and 21773 City or Town, State					
Balti	permit. Page Department or Important: If eny Injury or		21. Sign fure of Juneral S. Consee O'S Dornie Tuneral Wassing of Facility Home, P. A. 425 S. Conococheague St. Williamsport. MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate											
	rnysician /Medical Examiner		shock, or heartfailure. List on Immediate Cause (Final disease or condition resulting in death)	a		ELOMA			Interval Between Onset and Death 4 YEVIL S					
8760,	ate be executed hysician and the burial-transit	ledicai Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b										
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 20 No 9 □ Unknown	23c. If yes, outcome of pregnating the control of t	Ideath 3	Ectopic pregnancy Other (specify)			ite of delivery onth Day Year					
<u>a</u>	w requires that I been signed by should be deta	d by	Part II. Other significant conditions	s contributing to death but not res	ulting in the ur	nderlying cause given in Par		tobacco use con	tribute to the cause of death?					
Vital Records,		e Complete	25. Was case referred to medical			ge Ple	24a. Was auto perf 1 Yes	psy ormed? 2 X No	Were autopsy findings available prior to completion of cause of death?					
Division of Vi	ing Phys	ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident Pending investigal		ER/Outpatien 28b. Time of Injury	Othor	Nursing Home 5 Res 28d. Describe	idence 6 Oth						
Divi	e Hospital or Attend 24 hours after death 8 Funerel Director: , etely filled in by the f	0	3 Suicide 6 Could not determine 29a. Certifier 1 Certifying	building, etc. (Specified Physicien: To the best of my known	y)	occurred at the time, date	City or To	wn, State)	per or Rural Route Number,					
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in b	Medicai	(Check only one) 2 Medical Ex	eminer: On the basis of examina and manner stated.	tion and/or inv	/estigation, in my opinion, d	eath occurred at the time	date and place,	and due to the cause(s) d (Month, Day, Year)					
Ja	18		30. Name and address of person wh	no completed use of death (Item	n 23a) (Type,	04728		Septemi	30216,2005					
	Sta 'Regista	100	31. Date filed (Month, Day, Year) SEP 2 0 2	32 Rögistrar's Signa 2005	OMERA Iture	Print) VS SUTTE ZU	19, BATANO	W. /VI	21281					

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar		State of I	Marylan		artmen rtificate			and M		giene Reg. No.	005	31810
	Dhuniai	nge	1. Decedent's Name (First	Middle, Last)								2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic	al		heatley		lorsey						09	13	200	5 20:37 PM
	Examin	er	4a. Facility Name (If not in	stitution, give s	Madial	er)	601	4b. City,	Town, or	Location of	of Death			County of Dea	
200	Funeral	6 ° -	5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Under		If Under		8. Date of Birt (Month, Day		9. Bi	rthplace (State or Foreign
nge.	Funeral Director		212-16-7651	½	M 2□F	84	Yrs.	Months	Days	Hours	Min.	5/21/19	21	C	ryland
	pu >		Usual Residence of Deceding 10a. State 10b.	lent County		10c Cit	y, Town or Lo	antion							10d. Inside City Limits
	ahov ahov	ō													1X Yes 2 □ No
	28a-1	rect	Maryland	Wicomio	20	Sa	lisbur	10f. Zip	Code				10g. Citiz	en of What C	country?
	72 hours after death with the Maryland natural', or items 23a or 28a-f ahow aleal Examinat must be mulified at	Funeral Director	303 E. Coll	ege Ave	€.			2	1804				U	SA	
	death	ner	11. Marital Status		2. Was Decede	ent Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	- 1	4. Race - Am Black, Wh	erican Indian,
92	or its		1 Never Married 2		1 Tes 2	⊠ No		1 ☐ Yes		Specify:	1, 1 30110 1	mouri, sto.,		Specify: W	
Ö	ural',	d by	3 Widowed 4 D		Year or Date	os:	16a. Dece	dont's Hous	al Ossues	ti an					
7	in 72 n *nat	ojete	(Specify only	highest grade	completed)		(Give	kind of wo DO NOT us	rk done a	luring most	t of workir	ng	IBD. KIN	d of Busines:	s/industry
212	d within piene. rr then	Completed	Elementary/Secondary	0-12)	College (1-4	or 5+)	Own	er/op	erat	or			Dia	per Se	rvice
Maryland 21215-0036	ould be filed within 72 hours after death with the Marylan Menial Hygiene. arked other than "natural", or ttems 23a or 28a-f ahow atte avent, the Madical Examinat mad be inclifted at	To Be C	17. Father's Name (First, Andrew Hors									(First, Middle, eatley	Maiden S	Gumame)	
ary	s 1 and 2 should if Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Re	elationship (Ty)	oe, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	er, City or	Town, State,	Zip Code)
	1 and 2 Health tem 27 i		Oris Horsey		on		_			., Sa		ury, MC			
Baltimore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St.Stephens Cemetery 9/1									20c. Location - City or Town, State /05 Delmar, MD			
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Stylice Acensee 22. Name and Address of Facility Holloway Funeral Home Pr 501 Snow Hill Rd., Salis										fessi ury,	onal A	Association 804
			23a. Part1. Enter the dise shock, or heart failu	ase, or compli	cations that cau	sed the deat									Approximate Interval Between
A.	Physician		Immediate Cause (Final disease or condition	a	ather	rosde	10tico	cardi	10VG	scula	- de	SCA SE	6		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a consec									
		er	Sequentially list condition	s. b	Due to (or	as a conseq	uence of):								
	uted d ansit	m	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that in it and a works	* * .			·								
oʻ	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	c		as a conseq	juence of):								
8760,	ate be hysicie	edicai													ļ
9	artifica ing ph e as t	Med	IF FEMALE:	_									1		
Вох	The law requires that the death certificate be executed the has been signed by the attending physicien and oase 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregr in the past 12 month	ant		n 2 🗆 Feta	Ideath 3	Ectopic pr					2	3d. Date of de Month	elivery Day Year
o.	at the de by the a tached	ysic	1□Yes 2□No 9□Unknown		9 Unknow	nt at time of o	ieath 5t	Other (sp	өспу)						
Q _	that hed by deta		Part II. Other significant	onditions con	tributing to dear	th but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco us	e contribute	to the cause of death?
Records,	quires in sign uld be	ed by								_		1 🗆 1	∕es 2□]No 3□F	Probably 4 Huknown
000	as been 2 shouf	piete										24a. Was		24b. Were a	autopsy findings available
Ä		Completed											rmed? 227 No	death?	completion of cause of
Vital	sician: certifica rector,	Be	25. Was case referred to examiner?								of Death	(Check only o			
of \	Physician: this certific ral director,	ို	1 ☐ Yes 2 🗷 No	Н	ospital: 1 Inp		ER/Outpatie			4 🗀 190		ne 5□Resid			ecify)
		lon:		Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury	M 2	28c. Injury Work	rant ≀? Yes 2.⊟		28d. Describe f	now injury	occurred	
Division	deatl deatl tor:	licat		Could not be determined	28e. Place of	Injury - At h	ome, farm, st					28f. Location (S	Street and	Number or F	Rural Route Number.
Ω	F # F -	Certification:	4 🗌 Homicide	determined		, etc. (Speci		,	,,			City or Tov			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifier 1 2 C (Check only 2 N	ertifying Phys ledical Examin	sician: To the b per: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my or	ie, date an pinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s) a date and	and manner a place, and du	as stated. ue to the cause(s)
	within To the compl	Me	29b. Signature and title	centifier	11			290	c. License	number			29d. Date	signed (Mor	nth, Day, Year)
•	20			11/ess	K				Hoes	936 8	3		9	14/0-	5
	79		30. Name and address of	/ / / /	mpleted cause	of death (Iter	п 23a) (Туре,	Print)	St	Sali	Shun	y , M	0 2	21804	
27	Sta	ate	31. Date filed (Month, Da	2-1	32. Rg	strar's Sign	ature	1			101 - 1	1/11		0-7	
10	Regist	rar	51	P 162	עטט	Mice	St. A	parle	9						

Oris Horsey 213-16-7651

	1 - For Stata Registrar 1. Decedent's Name	(First, Middle, Last)	State of Maryl		artment of F rtificate of			.g. NG UU5	3 8
Physician /Medical Examiner	Agnes 4a. Facility Name (If	Marie	Herbe	rt	4b. City, Town, o	r Location of Deat	Month Septemb	Day Year Der 13, 200 4c. County of De	058:25 P M
uneral rector		oss Hospi	tal 7. Age (In)	rs. last birthday, 88 Yrs.		Spring If Under 24 Hrs Hours Min.	. 8. Date of Birth	Montgom	
a-f show	10a. State	10b. County Montgom		City, Town or L	ocation na Park	-			10d. Inside City Limits 1 ☐ Yes 3 ☐ No
3a or 28	10e. Street and Num 47 Jeff	_{ber} erson Ave	nue		10f. Zip Code 2091	2	10	0g. Citizen of What 0	•
al, or Itams 23a or 28a-f s Examiner must be motified by Euperal Director	3 Widowed	d 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	tispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify: Wh	ite, etc.
t, the Medical i	(Special Second	15. Decedent's Edu fy only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busines	s/Industry
atic evant, In	17. Father's Name (i			He	omemaker		me (First, Middle, M		Home
Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic evant, the Medical Examinet must be notified at once. To Re Completed by Funeral Director	19a. Informant's Na Anthony C 20a. Method of Disp 1 Strain 2 C	hristiani osition Cremation 3 F 5 Other (Specify)	/ Nephew 20 lemoval from State F	8668 b. Place of Disp cometery, cre t. Linco	B Doves F. Desition (Name of matory or other place) Oln Cemeto A Name and Addre	ly Way. Sep ery Sep ss of Facility Collin	Laurel, M Date tember 16 2005 s Funeral	Brentwo Home Inc	or Town, State
attending physician and for use as the burial-transit used in the burial-transit used in the burial Examiner	Immediate Cause (I disease or condition resulting in death) Sequentially list con if any, leading to imicause. Enter Under Cause (Disease or i that initiated events resulting in death) L	ditions, mediate lying	Acute Resp Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con	sequence of): Ovariar sequence of):					Interval Between Onset and Death 1 Day
etached for use as it	1	nonths?	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnancy	/		23d. Date of d Month	elivery Day Year
e d pe d	Part II. Other signifi	cant conditions co	ntributing to death but not	resulting in the t	ınderlying cause gıv	en in Part I.			to the cause of death? Probably 4 🙀 Unknown
page 2							24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	autopsy findings available completion of cause of s 2 No
ral director.	examiner?		fospital: 1 🔀 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	O.C.	ath (Check only one fome 5 - Reside	e) ence 6 □Other (Sp	ecify)
ed in by the funeral	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Yea.	At home, farm, si	Wor M 1□	yat k? Yes 2 □No		reet and Number or F	Rural Route Number,
completely filled in by the funer	29a. Certifier	1 ⊠ Certifying Phy 2 Medicel Exemi	building, etc. (Sp sicien: To the best of my ner: On the basis of exam	knowledge, dea	th occurred at the fir	me, date and place	city or Town a, and due to the ca urred at the time, da	use(s) and manner a	as stated.
complet			and manner stated.	Luck	29c. Licens	se number		9d. Date signed (Mor	
		A. Schwar	tz, M.D. 2			Drive,	#200, Si1	ver Sprin	g, MD 20902
State		h, Day, Year)	32. Registrar's S		P. I				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N& U () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month IS P M 13, 2005 Robert Ewell Heflin September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montg omery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) Sept 21,1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F Virginia Yrs. Director 224-32-1925 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Itams 23a or 28a-f show the Modical Examinar mount be notified at 1 ☐ Yes 2 X No Director Montgomery MD Derwood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7116 Blanchard Drive 20855 United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Montgomery County njury or other traumatic avent. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any njury or other traumatic svent page. 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Heflin Pearl Soutter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty W. Heflin/ Wife 7116 Blanchard Drive, Derwood, MD 20855 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Park Lawn Memorial Park Cemetery 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 21. Signature of Funeral Service Lieensee Deer Park Drive, Gaithersburg, MD 20877 22. Name and Address of Facility TUVER RAC Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Brain **Physician** In june DOXIT 4 duys /Medical Due to (or as a consequence of): Examiner deal enterculor 1 achy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗍 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heart Atherosclarotte 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 Yes 2 No 1 Yes 2 200 ours after death, nerst Director; After this certifica filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No Certification: To 1 Tes 1 Impatient 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Septenter. 13. 2004 00063088 iot 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohit Rastogi, MD 9901 Medical Center, Rockville, Md astogi 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 16 2005 Registrar

ntoi	nette E	3ar	rong Harman						_				
)5–06	363		Amend/Unpend	item#1.23	a,27,28a	Black In ⊡T⊾per	delible ME G8	48.1	Ensu LO/12	705 TT	opies	Are Legible.	
ern						d / Depa	artment	of H	ealth a	and Men	ital Hyg	i ^{ien} 2005	3 8 3
		_	Registrative IVE 10 174 apr		W,MbCb	Cei	rtificate	or L	Jeath	-		eg. No.	
	Physici	an	Decedent's Name (First, Mic		DEDDOM	C IIAD	TMAN				Date of Dea Month	Day Year	
	/Medio		ANTOINETTE 4a Feeiling Name (If not institut	ELIZABETH	BERRON	G NAN		Tours or	Location o		eptemb	er 17, 200	
	Examir	ıer	13218 Clifton	Road	uno o r)				Spri				
6	Funeral	8	5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under	1 Year	If Under 2		Date of Birth Month, Day	9. B	Somery inthplace (State or Foreign
3	Director		453.64.8379	1 ☐ M 2 🖾 F	64	Yrs.	Months	Days	Hours		Month, Day ${ m an.}~16$	1941 Fo	rt Worth, TX
9	p		Usual Residence of Decedent		1.0								
	aryla show	=	10a. State 10b. Cour	,		y, Town or Lo							10d. Inside City Limits 1X Yes 2 □ No
	Ba-f	ecto		tgomery	Si	lver S							
	death with the Maryland rns 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number	- D1			10f. Zip				1	0g. Citizen of What (Country?
	eath	era	13128 Clifto		cedent Ever in U.	S 13 1		904	enanic Orio	gin? (Specify	You or No	U.S.A. 14. Race - An	agean Indian
10	r Hen	표	1 ☐ Never Married 2X M	Armed F	orces?		f Yes, speci	ify Cubar	n, Mexican,	, Puerto Rica	n, etc.)	Black, Wh	
936	esi, o	by	3 Widowed 4 Divorc	If Yes G	IVO		1 ☐ Yes 2	IX No	Specify:			Specify: Wh	ite
5-0	72 ho	ted	15. Deced	lent's Education	,	16a. Dece	dent's Usual	Occupa	ition	t of working		16b. Kind of Busines	s/Industry
2	ithin ne.	Completed	Elementary/Secondary (0-12	2) College ((1-4or 5+))	of working		Walter Rei	
2	led w lygier her tr		47 February North Aside	5+		Bio	ochemi						of Research
anc	ntal H od ot	Be	17. Father's Name (First, Midd Robert Weld	on Berron	œ					·		Maiden Surname)	2.1
Ž	hould d Me mark matic	ဥ	19a. Informant's Name/Relation		6	19h Mailir	na Addrass	(Street a		tle E		eth Haubo r, City or Town, State,	
<u>@</u>	nd 2 s lith an 27 is treu		Robert Charl		/Spouse		-					-	land 20904
ē,	Hea Hea Herri		20a. Method of Disposition			lace of Dispo	sition (Nam	θ of	nodu	Date		20c. Location - City of	
Ë	and and and		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other							9/22/	2005 T	Brentwood,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minjury go other treumatic event, the Medical Examinal must be notified all ance.		21. Signature of Funeral Servi	ce Licepsee	1.					UNERAL			nar y rana
ä	8 8 1 8 8		Nancy F	1. Vecen	tu	11	N 008.	ew H	lampsh	hire A	ve, Si	, INC. ilver Spri	ng, MD 20904
			23a. Part1. Enter the disease, shock, or head failure. L	or complications that	caused the death								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition									onal Asphy	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):							
	LAGIMINE	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a consequ								
	ted	xaminer	Cause (Disease or injury	⊀ 500 10	(01 43 4 00113640	derice ory.							
	executed n and al-transit	xar	that initiated events resulting in death) Last	c	(or as a consequ	uence of);							
Box 68760	cate be executed physicien and the burial-transit	call		L _d									
68	as as	edi											
ŏ	death certificate be e attending physicie of for use as the bur	an/N	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna birth 2 Fetal		Ectopic pre	nancy				23d. Date of de	•
	he att	sicia	in the past 12 months?		nant at time of de		Other (spe					Month	Day Year
P.0	requires that the death cer een signed by the attendir hould be detached for use	Physician/Medical	9 Unknown Part II. Other significant cond	titions contribution to a	footh but out sou	iltino in the	- d b - i		a in Bank I		OZa Did tal		as the same of death?
Ś	w requires that s been signed to should be deta	by	Tarrii. Ottor significant cond	Thoms contributing to d	Jeans Dut Hot 1650	alling in the u	idenying ca	use give	mm Fanti.		238. Did toi	1	to the cause of death? Probably 4 Unknown
Ö	requ	Completed											
Sec.	e la	m Id									24a. Was a autops	y prior to	utopsy findings available completion of cause of
<u></u>	sicien: Th certificate rector, pag	e Co	06 181								1 Yes 2	2 No 1 9 Ye	s 2 No
₹	Physicien: r this certifica ral director, p	8	25. Was case referred to medi examiner? 1X Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	+ 2□ DO	Othe		of Death (Ch			ecify) at scene
Division of Vital Records,	g Phy er this	n: To	27. Manner of Death	28a Date		28h Time of		c. Injury	at	2 <u>8</u> d.	Describe ho	w injury occurred F	ound face.
<u>i</u>	Attending ir death. ector: After by the fune	Certification:		stigation 9/17/2	2005	6:50 I	м	Work′ 1 □ Y	es 2 X	. do	wn bet able	tween bed	and bedside
<u>Vis</u>	r Atte	tific		uld not be ermined 28e. Place	e of Injury - At ho ling, etc. (Specify			office		28f. i	ocation (St	reet and Number or F	Rural Route Number
0	itei o irs aft rei Di led in				und at h					Si	lver S	Spring, MD	Gural Route Number, Rd
	Hosp 4 hou Fune Fune	dical	(Check only 2 VMedic	lying Physician: To the cal Examiner: On the b	basis of examinat	wledge, death	occurred a vestigation,	t the time	e, date and inion, deatl	d place, and o	due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Hospitei or Attending Physicien: within 24 hours after death. To the Funerei Director: After this certific completely filled in by the funeral director.	Med	29b. Signature and title of cert	and mar	nner stated.			License				9d. Date signed (Mor	
	F≯≓%		Man	h	(10,00	AND			C.M.E			eptember 1	
			30. Name and address of pers	on who completed cau	se of death (Item	23a) (Type	Print)	0.0	لل 10 د	•	26	-brainer I	0, 2007
			MARGABRIT	DA.KE) Rou			Str	reet,	Balti	more,	Maryland	21201
	Sta		31. Date filed (Month, Day, Ye	ar) 32. F	Registrar's Signat	ture	arti						
16 :	Regist	ar	JEF &	# ZUUJ 29	Balletten A	5 166	September 1						

		For Unpend Item 2 Registrar Decedent's Name (First, Middle, Last,		001	incate of t	Death	2 Date of Dea	ath		3 8 3. Time of Death
Physician /Medical		EMONTAZ DELAN		HILL			Septem			07:40 A
Examiner	4	a. Facility Name (If not institution, give Howard County Gene			4b. City, Town, or Columb:	r Location of Deati ${ m ia}$	h	Howa	nty of Death	
Funeral Director		. Social Security Number 6. Se	-	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days 5 19	If Under 24 Hrs. Hours Min.		h v, Year)	9. Birthp	place (State or Fore htry) Yland
Dura A	-	Usual Residence of Decedent Oa. State 10b. County	10c. City	, Town or Lo	ecation				1	0d. Inside City Lin
with the Maryland a or 28a-f show the notified at	5	MD Howard		Elli	cott Ci	tv				XXYes 2
with the Mar a or 28a-f st Lee rotified Director	3	Oe. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?
23a c 23a c ust b	3	3585 Mt Ida Dri			210	145		U.S		
be filed within 72 hours after death vial Hygiene. Ital Hygiene. Ital Hygiene a "netural", or iteme 23a event. Ital Medical Examinat must Be Completed by Funeral	2	1. Marital Status 1. Narital Status 1. Narital Status 2. Married 3. Widowed 4. Divorced	12. Was Decedent Ever in U.3 Armed Forces? 1 ∐Yes 2 ŽNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		ace - Americ lack, White, cify: B1	
ygiene. ver than "netural; t, the Medical Exa		15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	rking	16b. Kind of		dustry
Hygier ther the Co		7. Father's Name (First, Middle, Last)		INO	ne	18. Mother's Nar	me (First, Middle,	None		
id be fill ental H ked ott ic even		Cleavon D. Hi	ll Jr.				nia T.			
should and Men marke umartic	- -	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailin	ng Address (Street				m, State, Zip	Code)
permit. Pages 1 and 2 should be liled within 72 no Department of Health and Mental Hygiene Important: If item 27 is marked other than "neturenty injury or other traumatic event, the Medical once. To Be Completed		Alethia Green-H	lemoval from State Ft	lace of Ospo emetery cren Lin 22	Solution (Name of natory or other place and Address A. Was	m 9/30	0/2005 nowden	Brent Brent Funera	twood Ho	own, State , MD me, P. 1
, K	+	23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death	V					10, 11	Approximate Interval Between
cate be executed Ephysician and Ephysician and Ephysician and Ephysician and Ephysician Examiner Calical Examiner		Sequentially list conditions, if any, reading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	aanda of).						
the attending the for use as scientification.)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy	,			Date of delive Month	ery Day Year
quires that if	5	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	1		ne cause of death?
ystctan: The law requires to certificate has been so director, page 2 should							24a. Was autop perio	rmed?	prior to cor death?	psy findings availant pletion of cause
ician: The certificate rector, pag		25. Was case referred to medical examiner?	fospital:		at 30 DDA Dth	or	ath (Check only o			
nding Physiath. r: After this continue funeral direction: To		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury 9-2/900 (Say Year)	ER/Outpatien 28b. Time of 6:4 ^l Fjury found	28c. Injun	4 Indising r	dome 5 Resident Resid			unk
ital or Attending P us after death. ral Director: After t iled in by the funers Certification:		3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify found at home		reet, factory, office		28f. Location (S City or Tow Ellicott	_		int Tu nber. Land
	T Cal		sician: To the best of my knowner: On the basis of examinat and manner stated.							
24 hours 24 hours Fune etely fi				_	29c. Licens	e number		29d. Date sign	and (Manth	
To the Hosp within 24 hou To the Fune completely fil	2	29b. Signature and title of certifier			230. Ellottis	e number			ied (Month),	Day, Year)
To the Hospital or Attending Phywithin 24 hours atten death. To the Funeral Director: After the completely filled in by the funeral Medical Certification; "	-	29b. Signature and title of certifier LOSA J 30. Name and address of pellon who ce		23a) /Tune	0.0	C.M.E.	S	Septemb		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 State
Registrar AMEND #4a PER FH 9/21/05 CCHD DB ** Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 11:10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health Kehab MARINER beurses nton If Under 24 Hrs. 5. Social Security Number 215-26-2413 -2+5-26-4130 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 T Yrs. Director arrya Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City I imits itam 27 le markad othar than "natural", or Itams 23a or 28a-f show othar traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3545 Funeral 20601 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: It itam 27 Is marked other then "natural", or Ital ☐Yes 2☐No 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 es, Give Specify: þ 3 ☑ Widowed 4 ☐ Divorced Specify: Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 umeste tomenak 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Genevia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benice M1) 20657 Mechanicsulle 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town State crematory permit. Pages Department of Important: It it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Peter Waldst ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Seg 22. Name and Address of Facility 20608 Adams Part 1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage 18ASZ /Medical Examiner tenio sclerte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed fotenseletre the attending physician and hed for use as the burial-tran Due to (or as a consequence of Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by the funeral within 24 hours after death To the Funaral Diractor:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 RJ TANWER mi Day, Year) 32. Registrar's Signature State 1 6 2005 Registrar

			1 - For State Registrar	State of Maryland	d / Depa	irtment of I	Health and	Mental Hyg	ien 2005	31816
16	- (A) (A) (A) (A) (A) (A) (A) (A) (A) (A)	-	Decedent's Name (First, Middle, Last)			inoute of	Death	2. Date of Dea	th	3. Time of Death
	Physici		Viola G. Howell					Septem]	per 12, 20	005 7:10 ^a
>	/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Dea		4c. County of De	
14			Southern Maryla	nd Hospital		Clint			Prince	George
Ь	- Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		. (Month, Day	. Year) 9. Bi	rthplace (State or Foreign country)
3	Director		579-32-6969 1U	83	Yrs.			Dec. 1	,1921 Sou	ıth Carolin
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary Firsh	ţ	Maryland Prince	George Su	itlan	đ				1 □ Yes 2 📉 No
	h the	Director	10e. Street and Number	000000		10f. Zip Code		1	0g. Citizen of What C	country?
	238 c		2521 Ewing Ave.	, Apt. 121,		207	746		U.S.A.	
	r dea	Funeral		12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		☐ Yes 2√2 No		,	Specify: B	
5-0036	tural tex	ba D	3 XWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		ent's Usual Occup				
5	n na	Completed	(Specify only highest grade	completed)	(Give	kind of work done OO NOT use retire	during most of wo	orking	16b. Kind of Busines:	s/industry
212	y with	E O	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	Super	visor			Food Ser	rvice
פ	al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,		
<u>a</u>	should be filed within 72 hours atter death with the Maryland of Mental Hygiene. marked other than "natural", or items 23s or 28s-f show imatic avent, the Medical Examinal marked attentions.	2	Harrison Gilmor	e			Martha	Ann Bro	own	
Maryland	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or R	ural Route Number	City or Town, State,	Zip Code) 20746
	s 1 and if Health item 27 other to		Marjeana Gutric		2521	Ewing	Ave.,	Apt. 12	, Suitla	and, Md.
altimore,	Pages 1 nent of h int: If ite		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re	amoval from State	ace of Dispos metery, crem	sition (Name of atory or other pla	Sept.	Date 17,2005	20c. Location - City o Irons ist Mar	r Town, State Sides.
<u>=</u>	rt. Pa rtmer rtant: njury		4 Donation 5 Other (Specify)	Ch	urch	of the	Lord Je	esus Chi	ist Mar	yland
Ba	permit. Pages Department of Important: If i any injury or once.	Ы	21. Signature of Funeral Service License	M0066	Q W	illiams	Funer	al Home,	P.A.	20640
- 2	See Se		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on		- 4	270 HAV	vthorne	Rd., Ir	ndian Hea	d, Md. Approximate
7,3	Dhysisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	trup	Hoor	+ fail	400	33(,	Interval Between Onset and Death
٤.	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ						
47	Examiner				(91010	myo	Pallic	1	
123		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque			-			
	ecute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last							
90,	cate be executed physicien and the burial-transit		resulting in death) cast	Due to (or as a consequent	ence of):					
98760	physi the b	dlcai	d							
×	The law requires that the death certificate has been signed by the attending I age? Should be detached for use as	Physician/Me	fF FEMALE:	Bc. If yes, outcome of pregnan	ncv				024 Day - 64	
ROX	atter 1 for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ Fetal 6	death 3	Ectopic pregnancy Other (specify) _	у		23d. Date of de Month	Day Year
o	the cy the	hysi	9 Unknown	9□ Unknown						
J.	res that the de signed by the a be detached i	by P	Part If. Other significant conditions conf	inbuting to death but not resul	Iting in the un	derlying cause giv	en in Part f.	23e. Did tob	acco use contribute (o the cause of death?
ğ	w require been sig should b	edt	Typerensi	on Demy	nti	9		1 □ Y€	s 2 No 3 □ P	robably 4 Unknown
ပ္သ	lawre as be 2 sho	piet	Hovanc	ed Mironic	Kei	ral di	SEGS€	24a. Was a	24b. Were a	utopsy findings available completion of cause of
Vital Records,		Completed						autops perform 1 Yes 2	ned/ death?	completion of cause of
Ita	cian: ertitic actor,	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only on		
0	Physician: r this certition ral director,	ို	1 192 5 9 140		R/Outpatient		4 Nursing F	lome 5 ☐ Reside	nce 6 Other (Spe	icify)
ב	ding f	lon	27. Manner of Death 1 ☑Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	28c. Injur Wor		28d. Describe ho	w injury occurred	
DIVISION	Attending or death. ector: Atterby the tune	icat	2 Accident Investigation 3 Suicide 6 Could not be	290 Place of Injury - At hor	no farm stra		Yes 2 □No	296 Lacation (Ct		
_	after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify))	er, ractory, onice		City or Town	eet and Number or R , State)	urai Houte Number,
	spita nours noral		29a. Certifier 1 Certifying Physi	ician: To the best of my know	rledge, death	occurred at the tir	me, date and place	and due to the ca	use(s) and manner as	s stated
	To the Hospital or Attending Physicis To thin 24 hous after death. To thin Funeral Director: Atter this cert completely tilled in by the tuneral direct	edical	(Check only 2 Medical Examination one)	er: On the basis of examination and manner stated.	on and/or inv	estigation, in my o	ppinion, death occu	urred at the time, da	ite and place, and du	to the cause(s)
	To the within to the comp	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	h, Day, Year)
)			\$60100	micwo, r	MD	000	05531	4	09 13	2005
1	0		30. Name and address of person who cor	npleted cause of death (Item:	23а) (Туре, F	rint)	0D C75	GOT O	VOOL HELD	MD 20745
,į	55		SYLVESTEN O (CC 31. Date filed (Month, Day, Year)	32. Registrar's Signatu		MILLI	10,010	, no T, O	NOW WILL,	1111 20 745
	Sta Registr		SEP 1 5 20		& A	ade				

			For State Registrar	State o	f Maryland / De	partment of F ertificate of			ene 2005 31	1817
	Physici	an	1. Decedent's Name (First, M			TT 1 1		2. Date of Death Month	Day V	Time of Death
	/Medic		Arnold	Paul		Herald		09	23 2005 11	1:52 AM
4	Examin	er	4a. Facility Name (If not instit		mber)		r Location of Death	1	4c. County of Death	
	Funeral		16818 Longfe 5. Social Security Number	11ow Ct	7. Age (In yrs. last birthda	Hagersto		8. Date of Birth	Washington 9. Birthplace	(State or Foreign
	Funeral Director		224-32-4358	X□M 2□F	75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, December		ginia
	p > 1		Usual Residence of Deceder 10a. State 10b. Co		10c. City, Town or	Lacation				nside City Limits
	fanyla shov	ě		,						Yes 2X No
	28a-1	Director	Maryland Was	hington	Hagerst	OWN 10f. Zip Code		10	g. Citizen of What Country?	
	h with		16818 Longfel	low Ct		21740			USA	
	deat	Funerai	11. Marital Status		edent Ever in U.S. 1: prces?	3. Was Decedent of F If Yes, specify Cub.	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - American Inc Black, White, etc.	dian,
36	s after	by Fu	1 Never Married XX 3 Widowed 4 Divo	Married 1 ☐ Yes If Yes, Gir	2X No ve No	1 ☐ Yes 🏋 No	Specify:	, , ,	Specify: White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Iteme 23a or 28a-f show event, the Medical Franis at must be retilised at	ed b		rced Year or D	16a De	cedent's Usual Occup	pation	1	6b. Kind of Business/Industry	,
215	within 72 ene. then "ne	Completed	(Specify only h Elementary/Secondary (0-	ighest grade completed)	(Gi	ve kind of work done DO NOT use retire	during most of world)	king	,	
	filed with Hygiene Ither that	Соп	3			dscaper			Landscaping	
pur		Be	17. Father's Name (First, Mic					ne (First, Middle, M		
Maryland	d 2 should be th and Mental I 7 is marked o treumatic eve	2	Felix Dudley 19a. Informant's Name/Relat		19h Ma	uling Address /Street		rginia As	Dury City or Town, State, Zip Code	
<u>Na</u>	ulth a		MaryLynne Her						m MD 21742	,
re,	Tea Hea		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	ce)	Date 2	Oc. Location - City or Town, S	State
Baltimore,	Pages nent of ant: if it ury or o		1 💥 Burial 2 🗆 Cremat	tion 3 Removal from er <i>(Specify)</i>	Jiaie	ven Cemete		7-2005 H	agerstown MD	
3alt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Ser	vice Licensee		22. Name and Addre	ss of Facility Re	st Haven	Funeral Chape	1
	40 = € O		J. Mark	Sup	revised the death. Denot	1601 Penns	ylvania .	Ave Hager	stown MD 2174	2 roximate
			23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final	List only of e cause on e	sech line.	and the mode or dyn	O C C	don L	Inter	val Between et and Death
	Physician /Medical		disease or condition resulting in death)		(or as a consequence of):	cu in i	acci	CHENT !	STROKE) 4	- weeks
	Examiner		Coguantially list conditions	b						
	D H	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequence of):					
V	and and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai E		4						
9	ifficate g phys as the			d.						
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnan		tcome of pregnancy birth 2 Petal death	3 DEctopic pregnancy	v		23d. Date of delivery	V ==
	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of death	5 Other (specify)		·	Month Day	Year
P.0	that the		Part II. Other significant cor	iditions contributing to d	eath but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to the cau	use of death?
Records,	luires that n signed b	d by	Acute re	nal insul	Hi ciency			1 ☐ Yes	2 No 3 Probably	4 Unknown
000	aw require s been sig 2 should b	Completed	luna c	ollapse	, ,			24a. Was an	24b. Were autopsy fir	ndings available
Re	The tav	mo	Diabe tes		us II	Aner	mia.	autopsy perform	prior to completion ed? death? No 1 Yes 2 N	on of cause of
Vital	sicien: Th certificate irector, pag	Be C	25. Was case referred to me examiner?				26. Place of Dea	th (Check only one		
of \	Physic this o	2	1 ☐ Yes 2 No		Inpatient 2 ER/Outpat	IGIT 3 DOM	er: 4 Nursing Ho		ce 6 Other (Specify)	
on	ding P h. After funera	tion	27. Manner of Death	28a. Date ending (Mon vestigation	of Injury 28b. Time th, Day Year) Injur	y Wor	yat rk? Yes 2 □ No	28d. Describe how	injury occurred	
Division	Attendiur death.	ifica	3 ☐ Suicide 6 ☐ C	ould not be 28e. Place	of Injury - At home, farm,				et and Number or Rural Rout	te Number,
Ö	s efte el Dire	Certification:	4 Homicide	build	ing, etc. (Specify)			City or Town,	State)	
	To the Hospitel or Attending Physicien: within 24 hours efter death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edicai		lical Examiner: On the b					use(s) and manner as stated. e and place, and due to the c	:ause(s)
	To th within To th compl	Me	29b. Signature and title of co	Atifier		29c. Licens		29	d. Date signed (Month, Day,)	Year)
			> Ke	mak	- $M.D$. 00	58181		09/23/2	005
	6		30. Name and address of pe	PEPRAH	382 5.0	e, Print) Clevelano	1 Ave	Hagersto	WN MD 21	1740
*	Sta Registi		31. Date filed (Month, Day,)	9 2005	Registrar's Signature	retes		<u> </u>		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygings OF

			State of Mary	nanu / D	Certificat	e of	Death		Reg. No.) 31	810
	Physician	1. Decedent's Name (First, Middle, Last Sister Cornelia						2. Dete of De Month	Day	Year	Time of Death 8:57 p.m.
	/Medical Examiner	4a Fecility Neme (If not institution, give				4	4b. City, Town, or L				5:57 p.m.
	ZXXIIII	St. Vincent Car			i lindo	1 Year	Emmitsbu	_	Frede		(0)
	Funeral Director	188-42-0314	x 7. Age (In	99 Y	Months		Hours Min.	8. Date of Bir (Month, De July 2	y, <i>Year)</i> 7 1906 1	Country) D. C.	(State or Foreign
	Maryland Ind at	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Frederi		c. City, Town	or Location Emmitsh	urg					nside City Limits 1 ĀYes 2 ☐ No
	after death with the Mar referes 23s or 28s-f si piner must be notified Funeral Director	10e. Street end Number 335 South Seton	Avenue		10f. Zip	Code	21727		10g. Citizen of W		
980	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at traumatic event, the Medical Examinar must be notified at traumatic event.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U,S.	13. Was Dece If Yes, spe 1 ☐ Yes	37	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	14. Race Black Specify:	- American II k, White, etc. White	
Maryland 21215-0036	ed within 72 hours e ygiene. ner than "natural", o nt, the Medical Exan Completed by	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16e. [Decedent's Usu Give kind of wo life. DO NOT u Teache:	rk done se retire	ation during most of wor d)	king	16b. Kind of Bus Religio Notre D	ous Com	munity
and 2	2 should be filed within and Mental Hygiane. Is marked other than aumatic event, the M	17. Fether's Name (First, Middle, Last) Daniel Aloysius	Herlihy	<u> </u>					Maiden Surmarne ia Walsh	•	
Mary	d 2 should I th and Meni 7 is marked traumatic	19a. Informant's Name/Relationship (7) Sister Camilla	, , ,				and Number or Ru ton Avenu		er, City or Town, S		
Baltimore,	Pages 1 an ent of Heal nt: If Item 2 y or other	20a. Method of Disposition 1	Removal from State	Oh Diese of I	Disposition /Na	ma of	Dame Cem	Data	20c. Location - C	City or Town,	State
Balti	permit. F Departmi Importar any Injur	21. Signature of Funeral Service Licens		Md. 21727							
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on eech line.	death. Do no	ot enter the mod	de of dyir	ng, such as cardiac	or respiratory a	rrest,	inte	proximate erval Between set and Death
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Advanc a			_				1	year
	je de la companya de			•	onsequence of)		liovascu	ılar di	sease	15	years
ν '0	filceta be executed g physician and as the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Due	e to (or as a co	onsequence of)						
ς 68760,	± 0 6	resulting in death) Last		to (or as e co	onsequence of):		Pro 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10				
Box	aftandi for use		d					ook Did	A-b	A-1	anne of death?
P.O.	as that the deeth cert gned by the attendin be datached for usa by Physician/N	Part II. Other significent conditions co	ntributing to death but no	ot resulting in	the underlying	cause gn	en in Part I.		tobacco use con Yes 2⊠ No		y 4 Unknown
of Vital Records,	been s should								en autopsy ormed?	availab	autopsy findings ole prior to ation of cause th?
E Re	Tha la ate ha pege Com							10	Yes 218No	1 □ Ye	es 2 No
Vita	Physician: r this cartific iral diractor, I: To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 [本No	Hospital:		tiont 20 D	OA Oth	26. Place of Dea		one) dence 6 □Othe	v (Consity)	
on of	ding Physic h. After this c funaral dire tion: To	27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Dey Ye	28b. Ti		28c. Inju Wo			how injury occurre		
Division	To the Hospital or Attending Physician: The law within 24 hours efter deeth. To the Funeral Director: After this cartificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S		m, street, factor	y, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural Ro	oute Number,
	he Hospita in 24 hours he Funeral pletely filled edical C	29a. Certifier (Check only one)	rsician: To the best of m Iner: On the basis of exa and manner stated	amination end	deeth occurred /or investigation	et the ti	me, date and place opinion, death occu	, and due to the rred at the time,	ceuse(s) and mar date and place, a	nner as stated and due to the	d. • cause(s)
)	vithin To the compl	29b. Signature and title of certified	Cr	116	UM 29	c. Liceos	se number	5	29d. Date signed	(Month, Day	, Year)
	3	30. Name end address of person who o					1				
	State	Alan Carroll, 31. Date filed (Month, Day, Year)	M.D. 310		h Seto	on A	venue	Emmits	burg, M	laryl an	nd 21727
	Registrar	CED 9 9 2005	Et a	N ON	Section 1						

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible Amend 1ten 5 per th 8847 9-29-05 vt

		Amend State	item 5 per 1 of Maryland/L				nd Mental Hy	giene						
		Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	e of l	Death	2. Date of D	Reg. No	05_	3. Time of	Death 9			
Physic /Medi		JAMES LAWRENCE HES	SS				SEPTEM	BER 22 2	2005 B	:50	РМ			
Exami		4a. Fecility Name (If not institution, give street and				Location of	f Death	4c. County						
		SACRED HEART HOSPITAI	7. Age (In yrs. last birt		JMBEE	RLAND	24 Hrs. 8. Date of Bi		EGANY	ice (State i	or Foreign			
Funeral Director		217 28 9787 11 M 2□F		Yrs. Months		Hours	Min. (Month, D)	ay, Year)	9. Birthple Country MARYL		ii i oreigii			
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location					100	d. Inside Ci	ity Limits			
Maryl -f sho	tor	MARYLAND ALLEGANY	FROS	TBURG						¼ Yes	2 🗆 No			
or 28	Director	10e. Street and Number			Code			10g. Citizen of		y?				
eath w	Funerai	46 E. MAIN STREET	ecedent Ever in U.S.	13. Was Dece	2153		in? (Specify Yes or N	U.S	ce - American	n Indian.				
d within 72 hours after death with the Maryland within 72 hours after death with the Maryland jiene. It than "natural", or items 23a or 28e-1 show the Medical Examiner must be notified at	/ Fun	1 Amed 1 Vever Married 2 Married 1 Very Married 1 V	Forces? s 2 No Give	If Yes, spe		n, Mexican, Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	Bla Specif	ick, White, etc					
hours af	ed by	3 ☐ Widowed 4 ☐ Divorced Year o	r Dates:	Decedent's Usu				16b. Kind of B			MANAGE AND AND AND AND AND AND AND AND AND AND			
within 72 ene. than "na	Completed	(Specify only highest grade complete	ed)	(Give kind of w life. DO NOT i	ork done d ise retired	during most ()	of working			Sity				
0 5 5 5		12	RE	TIRED A	IR FO				ITARY					
d be file	To Be	17. Father's Name (First, Middle, Last) GEORGE T. HESS. SR.					r's Name <i>(First, Middl</i> e ERY WILLI <i>A</i>		πe)					
ife, Marylar s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ex	F	19a. Informant's Name/Relationship (Type, Print)		. Mailing Addres	s (Street		r or Rural Route Numb		, State, Zip C	ode)				
and 2 and 2 lealth m 27 i		JUNE TIMNEY, SISTER	1			r., LC	ONACONING,							
0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro	cemeter cemeter	f Disposition (Na ry, crematory or GAP VET:	other plac			20c. Location			LAND			
Dalitimo permit. Pages Department of Important: If i any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Eugeral Service Licensee	1 500099											
Dermi Depa Impo any i		21. Signature of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P. A. FROSTBURG, MD 21532												
		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do r in each line.						10	Approximat nterval Bet Onset and I	ween			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	etastatic to (or as a consequence	Cun	5	ch	ncer-f	rimary	1	man	iths			
Examiner			to (or as a consequence t	u,	nki	- owi	ncer-f	,						
be sit	iner	Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of	of):										
ou, be executed ician and burial-transit	Examiner	that initiated events c	to (or as a consequence of	of):										
6 / OU, sate be executed obysician and the burial-transit	icai	d												
X OX Sertifica ding pt	/Med	IF FEMALE:	outcome of pregnancy											
The COIGS, P.O. BOX 08/ The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/M	in the past 12 months?	e birth 2 Fetal death egnant at time of death	3 ⊟Ectopic p 5 □ Other (s					ate of delivery onth Di		Year			
at the I by the stache	Phys	9 □ Unknown	iknown											
signed bed	b	Part II. Other significant conditions contributing to		, ,				tobacco use con Yes 2 No						
w requires to been signer should be	ompleted	Cerebrovascular	Acceles 1	, , , ,	-		24a. Was		Were autops					
The tav	dmo:	_ Corabity is cured	peacen				auto perí 1 ☐ Yes	psy ormed?_	prior to comp death? 1 Yes 2	oletion of c	ause of			
ysician: Tysician: Tis certificat	BeC	25. Was case referred to medical examiner?			-		of Death (Check only	one)						
Physi Physi r this c	5.		☐ Inpatient 2 ☐ ER/Outle of Injury 28b. 3		28c. Injun Worl		sing Home 5 Res	how injury occur		_	_			
r Attanding for death. iractor: After by the funer	ation	Natural 5 ☐ Pending (Natural 2 ☐ Accident investigation		njury M		k? Yes 2 □ N								
To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate is completely filled in by the funeral director, pag	ertification:	3 Suicide 6 Could not be determined 28e. Pla	ace of Injury - At home, fa ilding, etc. (Specify)	rm, street, factor	y, office			(Street and Numb wn, State)	per or Rural F	Route Num	ber,			
spital ours at ours at ours at ours at our ours at our output out	O	29a. Certifying Physician: To	the hest of my knowledge	a death occurred	at the tin	ne date and	t place, and due to the	Cause(s) and m	anner as stat	ed				
To the Hospital or within 24 hours afte To the Funaral Discompletely filled in	edical	(Check only 21 Medical Examiner: On the	e basis of examination and anner stated.	d/or investigation	i, in my o	oinion, deat	h occurred at the time	date and place,	and due to th	ne cause(s)			
To t Within To th	Σ	29b. Signature and title of certifier		29	c. License			29d. Date signe						
180		30. Name and address of person who completed co	ause of death (Itam 22-)	(Type Briet)	D 3	-124	+4	9/2	3/20	05				
31,		JESUS H. TAN, M.D., 10			EEK F	ROAD,	FROSTBURG,	MD 2153	32					
	ate	31. Date filed (Month, Day, Year) 32	Registrar's Signature											
Regist	rar	SEP 2 9 2005	Bour It	GOENES										

State of Maryland / Department of Health and Mental Hygie [26] 05 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:25 P M September 18 2005 <u>Bettie Jane Hornbaker</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington If Under 8. Date of Birth (Month, Day, Year) Aug. 25, 1934 If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 6. Sex Months Days Hours 1 □ M XXF 71 Maryland Director 216-30-3786 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1XXYes 2 □ No Director Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 372 Cornfield Drive 21795 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. □Yes 2No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 4X Divorced 3 ☐ Widowed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then ury or other traumatic event, I'm Ms Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Reichard Moats Pearl Auralia Higgins Milton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13643 Big Pool Rd. Clear Spring,MD Patricia Gehr - Sister 20a. Method of Disposition

1 → Burial 2 → Cremation 3 → Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Cedar Lawn Mem. Park Sept.21,2005 Hagerstown, Maryland 21. Signature of Funeral Service OSborned Tuner Fadiliv Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner Due to (or as a consequence of). attending physician a for use as the burial-Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9☐ Unknown 9 Unknown ģ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 17 Natural

☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminat: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. ical 29a. Certifier 29c. License number 29d. Date-signed (Month. Dav. Year) 29b. Signature and title of cert no completed cause of death (Item 23a) (Type, Print) 0 istrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 31821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Helen Delphey Hargett September 12, 2005 10:45p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🔯 F Yrs. 212-38-9408 88 Director May 29, 1917 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner hast be notified at 1X Yes 2 No Maryland Frederi<u>ck</u> Frederick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Catoctin Avenue 21701 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or iteme 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth eny linjury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be Clarence G. Delphey, Sr. Nina E. Deater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8105 Frosty Field Court Richard L. Hargett, Jr. / Son Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State September 19, 2005 4 Donation 5 Other (Specify) Mt. Olivet Cemetery Frederick, Maryland 21. Sign were of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chrones Dipphocytice Due to (or as a consequence of): Physician Kso disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Zeith 28b. Time of 28d. Describe how injury occurred of Hospital or Att.

hours after death.

et Director: After

by the fur Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral E 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature apd 29d. Date signed (Month, Day, Year) aux nn, M.D. 300 W. Ninth Street Frederick, Maryland 21701 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Kaufmann, M.D. 31. Date filed (Month, SEP 1 State Registrar

		For	ate of Maryland		it of Health and		2000	01000	
		State Registrar Deceden;'s Name (First, Middle, Last)		Certificat	e of Death	2. Date of Deat		3. Time of Death	
Physicia /Medica		Lille M. Huds	ion			Septemb			
Examine	_	a. Facility Name (If not institution, give street	and number)	4b. City,	FASTON		4c. County of Dear	1	
Funeral		The Memorial Social Security Number 6. Sex	7. Age (in yrs. la	Months	r 1 Year If Under 24 Hr Days Hours Mir	s. 8. Date of Birth		hplace (State or Foreign	
Director		July Residence of Decedent	78	Yrs.				orida	
Maryland 1 show	_	0a. State 10b. County		Town or Location	,			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
h the Maryland r. 28a-f show	Funeral Director	MD Caroliv Oe. Street and Number	ne Fe	ederals 101.zi	burg	10	0g. Citizen of What Co		
23a or	alDi	4603 Prestor	Road		21632		USA		
6 Se or Itams 23	une	1. Marital Status	/as Decedent Ever in U.S rmed Forces? □Yes 2.02No		dent of Hispanic Origin? (cify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit		
0330 US 8	þ	lf lf	Yes, Give ear or Dates:	1 🗆 Yes	2 No Specify:		Specify: B1	ack	
15-003	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	16a. Decedent's Usu (Give kind of wo life. DO NOT L	al Occupation ork done during most of wise retired)	orking	16b. Kind of Business	'Industry	
d 2121 d 2121 filed within Hygiene. wither than "	Com	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	Process:	ng Line W		Janning.	Industry	
tal Hilling out out	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle, M Known	Maiden Sumame)❤		
Maryla Maryla 12 should h and Men 7 is marke traumetic	2	UN KNOWN 19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailing Addres	s (Street and Number or F		, City or Town, State, .	20	
re, M		Annie Vea	20b Pl	1309 Hea	then Hill K		nore, MD		
2 8 5 E S		20a. Method of Disposition 1	Co	metery, crematory or	other place)	,	Cambrid	AA- /- /	
Baltimo		21. Signature of Funeral Service Licensee	1 2	22. Name a	nd Address of Facility	HOME, P.	A.	7.7	
m 902 2 9	Examiner	23a. Party Enter the disease, or complication	Jenry ns that caused the death	5101	Nashington	USt Cam	bridge, 1	Approximate	
Physician		Immediate Cause (Final	on sextine.	Henry	Fillip			Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	LW/Wie	16	1 ~	ח	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury b. Kight Heart tall was class full menow but to (or as a consequence of): Chanulomatous no pure the list no element to the control of th					tension	Ways	
scuted nd transit		that initiated events				B. fibres	sis	years	
60, be exe sician a burial-	6 8 6 8 E						losis	Uears	
2 2 2 2					1	- Jewes Co			
Box 68' leath certificat attending phy	Physician/Med	in the past 12 months?	yes, outcome of pregnal Live birth 2 Fetal Pregnant at time of de	death 3 □Ectopic p			23d. Date of de Month	livery Day Year	
P.O. that the deed by the adetached is	hysic		Unknown	3 0 0 0 0 0	pecity)				
	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown		
w requi	ompleted	Who situ				24a. Was a	24a. Was an 24b. Were autopsy findings available		
Division of Vital Records, to Attending Physicien: The law requires tafer death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	omp	Opesing				autops perform		completion of cause of	
Vita	n; To Be C	25. Was case referred to medical examiner?	tal: 🚅		Other	eath (Check only on	_		
g Physer this seral di		27. Manner of Death 28	Ba. Date of Injury (Month, Day Year)	ER/Outpatient 3 D 28b. Time of Injury	28c. Injury at Work?		ence 6 Other (Spe ow injury occurred	icity)	
Sior tendin leath. tor: Aft	ertification;	2 Accident investigation		М	1 Tes 2 No	28f Location (St	reet and Number or R	ural Route Number	
Divi	ertifi	4 Homicide determined	Be. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	гу, опісе	City or Town		urai rioute rumber,	
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To the within To the comple	Me	29b. Signature and title of certifier	Timb		Oc. License number	1	9d. Date signed (Mon		
		30. Name and address of person who complete	ated cause of death (from	23a) (Type Print)	D 6864		7/12/05		
		David A. Sto 4	t, m.D.	219 5.W	shington	st. East	on, His 2	1601	
Sta Registr		31. Date filed (Month, Dasep 14 2	005. Regiskir's Signa	ture & Appe	V6804 Ishington				

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 13,2005 11:59 A M David Μ. Ivev /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SALISBUR NICOMICO PANINSU/A 2/01/2/ If Under 1 Year | If Under 24 Hrs. 6. Sex 1X M 2 ☐ F 8. Date of Birth (Month, Day, Year) Apr. 24,1928 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 245-28-7662 77 Yrs. North Carolina Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Taxarked other then "natural", or Itams 23a or 28a-f ahow reumatic event, the Modical Exercitor and the notified at returnation event, the Modical Exercitor and the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Virginia Henrico Richmond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23233 2154 Cedarfield Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1945— If Yes, Give Year or Dates: 1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Sales of Elementary/Secondary (0-12) College (1-4or 5+) Pipes and Joints Company President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth atty injury or other treumatic event of these. William Roy Ivey Lucille Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte G. Ivey/Wife 2154 Cedarfield Lane, Richmond, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State 9/16/2005 4 ☐ Donation 5 ☐ Other (Specify) Hollywood Cemetery Richmond, Virginia 22. Name and Address of Facility Henry W. Woody Funeral Home 1771 N. Parham Road, Richmond, Virginia 23229 21. Signature of Funeral Service License Party. Enter the disease, or complications that shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronin ears /Medical Due to (or as a consequence Examiner Thero Sclerosis Requestially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical David Ivey 345-28-7662 tF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an The law autopsy performed 2 No 1 Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funeral Direct 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of 3 mo 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 (20) Rmc Ethertan, mo-State 2005 Registrar

CT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-06263 State of Maryland / Department of Health and Mental Hygiene Jackson, Victor 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Jackson Victor Noah September 12, 200
4c. County of Death 2005 1:31 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. | June 13 1975 | Maryland University of Maryland Shock Trauma
5. Social Security Number 6. Sex 7. Age (In yrs. last birth 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**™**M 2□ F 214-88-2749 30 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or iteme 23e or 28e-f show troumetic event, the Modical Exerciper man be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 414 Hearn Lane U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ges 1 and 2 should be filed within 72 hours after on of Heelih and Mental Hygiene.

If flem 27 is marked other than "natural", or flex or other treumatic event. 1XYes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1993-95 1 ☐ Yes 2 No Specify: Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Victor Jackson Beverly Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bererly Jackson (Mother) 300 Apt 201 Glen Ave. Salisbury, Md. 2180 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page:
Department o
important: If |
any injury or Springhill Mem.Garden / 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Md. 21. Signature of Funeral Service Licenses StewartresFufferal Home Gladys B. Stewart 821 West Rd.Salisbury, Md.21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multis questot Physician Wonds with /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760 Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. Phys 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠ es 2 □ No page 2 s hes 1 Yes 2 🗆 No Hospital or Atlanding Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ty⊒Yes 2 No 2 this 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After t Certification; 1 Natural subject shot by police 5 Pending after death. 8/05 D: ON HOURS 1 ☐ Yes 2 No investigation 2 Accident filled in by the 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 414 Harre Leac Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital of within 24 hours at To the Funeral D completely filled i Medical

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

wolon U

THE ODURE M. Fine 31. Date filed (Month, Day, Year) SEP 1 6 2005

DHMH 17 Rev 1/2001

ORIGINAL

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anna

32. Reastrar's Signature

reside

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCME

29c. License number

111 Penn Street Baltimore, Maryland 21201

Teles bury, Many land

29d. Date signed (Month, Day, Year)

September 13, 2005

			i icasc	State of Ma					•		-	•	
			1 - For State Registrar	State of Mai	rylariu	Certifica			wental n		71115	31825	5
			Decedent's Name (First, Middle, L.)	ast)		00/11/100	210 07 2		2. Date of D	Reg. No).	3. Time of Death	_
	Physici		Mesley Ju	hnson					Septen	nber	16 200		М
	/Medio		4a. Facility Name (If not institution, gi					Location of Deat			. County of De		
			University of N	laryland n			Ba	ltimore			n/9		
	Funeral Director		217-36.2271	Sex 7. Age 107M 2□F	(In yrs. las	t birthday) If Und Month	der 1 Year ns Days	If Under 24 Hrs Hours Min.	. (Month, E	irth Day, Year,	1940 W	Birthplace (State or Foreig Country) 10 Y 1/10 17 d	j n
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Fown or Location						10d. Inside City Limit:	s
)	Maryl f sho	tor	MD Dorch	hester	Ca	Mbrid	^^					1 12 Yes 2 □ N	
	r 28a	irec	10e. Street and Number	163761			Zip Code			10g. Ci	tizen of What	Country?	
)	th wit	Funeral Director	409 Campe	r Street	+		2161	13		i	USA		
	ar dea	uner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was De	cedent of His pecify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or N to Rican, etc.)	lo-	14. Race - Ar Black, Wi	nerican Indian, hite, etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:)	1 ☐ Yes	2 1 No	Specify:			Specify:		
5-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Thygiene. The Hygiene marked other than "natural", or Itams 23a or 28a-f show marked other than "natural", or Itams it is marked other than "natural" or matter incitified at	ted	15. Decedent's E	ducation	-	16a. Decedent's U	sual Occupa	ition		16b. F	(ind of Busines	ack	
215	thin 7 e.	Completed	(Specify only highest girls Elementary/Secondary (0-12)	College (1-4or 5+	.)	life. DO NOT	work done d Fuse retired)	luring most of wo)	rking				
2	filed wi Hygien other th	Cor	12	Al		Custo	diar					FEducation	N
anc	e d ta	Be	17. Father's Name (First, Middle, Las					18. Mother's Nat					
Maryland	should nd Mer marka umatic	2	Weslev 7 19a. Informant's Name/R lationship			19b. Mailing Addre	ess (Street a		y y C			. Zip Code)	
	C1 c2 '22 E2		Dorothea										3
altimore,			20a. Method of Disposition		20b. Plac	e of Disposition (A	Name of other place	9)	Date	2/ % . L	ocation - City	or Town, State	-
Ĕ			1 ☑ Burial 2 ☐ Cremation 3 (14 ☐ Donation 5 ☐ Other (Spec		Beth	nel Cemo	otenii	9/3	12/03	Car	ubrida	e, Marylan	d
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice	nsee		22. Name	and Addres	CERCI HE	Me, P. A.				
	20 5 % OI		23a. P. 1. Enter the disease, or cor	Henry	ho dooth	1510 W	ashin	GTON ST.	Cambr	idar	maryl	and 21613	
			shock, or heart failure. List only	one cause on each line).	DO NOT BRIEF THE IN	lode of dying	g, such as carola	c or respiratory	arrem,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	aDue to (r as a	consequer	ace of:							
	Examiner		O TOTAL PART OF THE PART OF TH	h Acut			lure					lmonth	
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequer	nce of):	lure dis					Lmonth	
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a			ais	ease				LUNIONFH	
760,	ate be executed nysician and he burial-transit	cai E	· ·										
687	ifficate g phy: as the			_ d.									
Вох	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			nregnancy				23d. Date of d	,	
о. П	ie dea the at hed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tii 9☐Unknown							Month	Day Year	
<u>.</u>	that the de led by the a detached i	Phy	Part II. Other significant conditions	contributing to death but	not resulti	ng in the underlying	a cause give	n in Part I.	23e. Did	tobacco	use contribute	to the cause of death?	
Records,	98	d by					g g				/	Probably 4 Unknown	n
CO	sw requires been size should be	Completed							24a. Wa		24b. Were	autopsy findings available	е
Re	The lav ate has page 2:	mo							perl	opsy ormed? 2 \(\subseteq\) No	death?		
Vital	ysician: Th	Bec	25. Was case referred to medical examiner?					26. Place of Dea					
ot	Physic this c	70	1 ☑ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient		VOutpatient 3□ I		# 🗆 Nursing F	lome 5 Res			pecify)	
ם	ding Ph h. After thi funeral	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	Bb. Time of Injury M	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe	now inju	ry occurred		
Division of	or Attand after death Director:	ifica	3 Suicide 6 Could not	28e. Place of Injury								Rural Route Number,	
ā	talor rs afte sal Dire ed in t	Certification:	4 Homicide determine	building, etc.	(Specity)				City or To	own, State	9)		
	To the Hospital or Attanding Physician: within 24 hours after death as a fore death from the certified completely filled in by the funeral director, completely filled in by the funeral director,	edical	(Check only 2 Medical Exa	hysicien: To the best of miner: On the basis of each manner state	examination	and/or investigation	on, in my op	inion, death occu	irred at the time	, date an	d place, and di	ue to the cause(s)	
	To the within 2 To tha Complet	Me	29b. Signature and title of certifier			2	29c. License	number		29d. Da	ite signed (Moi	nth, Day, Year)	
			> Serena M	· (Jam MI))		166	80		Sep t	ember	16, 2005	
			30. Name and address of person who	completed cause of dea CAAM M 9 2005 P	ath (Item 23	3a) (Type, Print) 1302 S	st	SE, W	ashing	ton	DC	20020	
	Sta Registi		31. Date filed (Month, Day, Year)	9 2005 Negistra	's Signatur	& So	who		J				

State of Maryland / Department of Health and Mental Hygiene 2005 31826 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Sept. Day Year **Physician** 12, 2005 12:15P [™] Ella Beatrice Jackson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner La Plata
If Under 1 Year | If Under 24 Hrs. Civista Medical Center Charles 8. Date of Birth (Month, Day, Year) Dec. 14, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X F Yrs. 1926 Virginia 577-38-4612 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f ehow empt injury or other traumatic event, in Mardical Examinar mast be notified at once. 1 ☐ Yes 2 X No Charles Waldorf Maryland Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1226 Bannister Circle 20602 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: African Specify: 3 ☑ Widowed 4 □ Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst US Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Warrenton Jackson Betty Lee Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kim A. Thompson - Daughter 1226 Bannister Circle, Waldorf, MD 20602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans' Cem.9-19-2005 Cheltenham, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. O. Box 156 M00053 Huntt Funeral Home Waldorf, MD 20604 K Cun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hermon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine sicien and e burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical ending physical use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by Division of Vital Records, BZ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 🗌 Yes 1 Tyes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Inpatient 1 🗆 Ye 20 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturat 5 Pending death. 1 Yes 2 No investigation within 24 hours after death To the Funerel Director; a completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D-37174 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Song C. Chon, MD Cenna Medical Center 7C Post Office Road Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 6 2005 Registrar

	1	For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla		ificate of L			Reg. No.	3 8 Z
Physicia /Medic	าก		allace	Johnson		Sr.	Sep 26,	2005 Ye	^{ar} 2:55am ^м
Examin	er	4a. Facility Name (If not institution, give s Cumberland Villa N 5. Social Security Number 6. Sex	ursing Home	rs. last birthday)	4b. City, Town, or Cumberl If Under 1 Year		8 Date of Birth	4c. County of D	y
Funeral Director			IM 2□F 66	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jul 1, 1	939	Birthplace (State or Foreign Country)
Maryland	Ī	10a. State 10b. County MD Allegany		City, Town or Loc					10d. Inside City Limits 1 □ Yes 2 □ No
3e or 28a	I Direc	10e. Street and Number 135 N. Mechanic S	treet		10f. Zip Code	21502		10g. Citizen of What	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 le marked other than "natural", or items 23e or 28e-f ehow any Injury or other traumatic evant, the Medical Examination must be institled at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Specify:	American Indian, White, etc. White
ithin 72 hou be. nan "nature Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give k		ition furing most of work)		16b. Kind of Busine	
be filed w ital Hygier id other th	Be	12 17. Father's Name (First, Middle, Last)		Labore		_	e (First, Middle,	Tire Co. Maiden Sumame) er Johnso	n
2 should and Men le marke raumatic	To	Wallace Johnson 19a. Informant's Name/Relationship (Ty Kenneth Johnson J	pe, Print)		Address (Street a	and Number or Rui		r, City or Town, Sta	
permit. Pages 1 and 2 Department of Heelth a Importent: If item 27 It any Injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	20l	o. Place of Dispos cemetery, crem	ition (Name of atory or other place eral Home	9)	Date 9/28/2005	20c. Location - City	or Town, State
permit. Pa Departmer Importent any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Name and Address Scarpelli	s of Facility Funeral Ho	ome, P.A.	0.000,010	
Pnysician /Medical		23a. Part Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the doe cause on each line.	Nec	r the mode of dyin	g, such as cardiac	or respiratory ar	land, MD 21	Approximate Interval Between Onset and Death
ifficate be executed ax g physician and as the burial-transit as	al Examiner	Sequentially list conditions, if any, leading to immediate cause the library that initiated events resulting in death) Last	Due to (or as a con:						
The law requires that the death certificate to has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
quires that in signed by	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause give	en in Part I.			te to the cause of death? Probably 4 Denknown
	Completed							prior deat	e autopsy findings available r to completion of cause of th? Yes 2 \(\square\) No
ding Physician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea.	2 ER/Outpatient 28b. Time of Injury	28c. Injun World	4 Lar Nursing H	ome 5 Resid	dence 6 Other (Specify)
or Atten after deat Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, stc. (Sp	t home, farm, stre a ify)	et, factory, office	-	28f. Location (S City or Tox		or Rural Route Number,
e Hospitel or 24 hours afte e Funeral Dir etely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certify r	13		29c. Licens	9 number 36766		29d. Date signed (A	
		30. Name and addless of person who co	ompleted cause of death (Item 23a) (Type, I	10	30700		7-20	-2005
Sta Registi		Vikramaditya Poo 31. Date filed (Month, Day, Year) SEP 3 0 2	nai M.D. 32. Registrar's S	ig <i>n</i> ature	eton Drive	e Cumber	land MD	21502	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 16 Sept. 2005 P^{M} 5:07 MARIE CONWAY JONES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO SALISBURY, MD. 21804 SALISBURY REHAB & NURSING CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 M 2 XF Director 219-05-3476 101 May 8, 1904 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "naturel", or Items 23e or 28a-f show dical Examiner must be ruitified at 1 ☐ Yes 2 🖔 No Marvland Wicomico Salisbury Direct 10f. Zin Code 10g, Citizen of What Country? 10e, Street and Number 21801 1017 North Delano Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 →Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) laborer Factory 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Heatth and Mental 1 Wilson William Conway Estella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1017 N. Delano Avenue - Salisbury, MD 21801 Allen C. Brown, Sr./nephew 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) St. James Free Cem. | 09/24/2005 Quantico, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 rart1. Ent. I he disease, or complications that cause to be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one is use on each light. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Due lo (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cluste (Disease of Lipsy) that initiated events resulting in death) Last Due to (or as a cr insequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IE FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 🗌 Yes 2 -NO Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours after To the Funerel Dire 29a. Certifier 1 🚅 🕊 Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 228348 nas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 31. Date filed (Month, Day, Year) State 9 2005 Registrar

DHMH 17 Rev 1/2001

JONES

		1	For State Registrar	State of Mary		rtment of He			ene 005	31829
			I. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Ye	3. Time of Death
	Physicia		Katherine		JOPP.	ΥΥ		Month	11 200	5 6:20 ^{BM™}
- A (2)	/Medic Examin		a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or			4c. County of D	omery
10 mg		100	0110-9-	eneral Ho		Olne	-2	8. Date of Birth		Birthplace (State or Foreign
	Funeral	5	5. Social Security Number 6. Sex 1217-30-0429	M 2 F 7. Age (//	n yrs. last birthday) 84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 22	Year)	Country) Maryland
, V.	Director		Usual Residence of Decedent		0 1			Mayzz	122-	
	yland		10a. State 10b. County	10	Oc. City, Town or Loc					10d. Inside City Limits 1 Yes 2 No
	Mar.	ctor	MD Montg	omery	Rock	ville				
	or 28	Director	10e. Street and Number	D #	202	10f. Zip Code 208	5.2	1	0g. Citizen of What U.S.A	
	ath w		14635 Bauer	Drive #	302		spanic Origin? (Spe	cify Yes or No-		American Indian,
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Madical Examiter nutsible notilised at	Funeral	11, Marital Status 1 ☐ Meyer Married 2 ☐ Married	Armed Forces? 1 Yes 2 No	łf	Yes, specify Cubai	n, Mexican, Puerto i	Rican, etc.)		Vhite, etc.
38	urs aff	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	Black
Ö	2 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	ent's Usual Occupa	ation during most of working)	ng	16b. Kind of Busin	ess/Industry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+))		Home	ے
7	led w lygier her th		7th 17. Father's Name (First, Middle, Last)		DOI	estic	18. Mother's Name	(First, Middle, I		
anc	d be find be of	ñ	Charles Will	iam Topp	37		Tere	esa Mag	gruder	
Maryland 21215-0036	should bd Me mark imatic	5	19a. Informant's Name/Relationship (T)		19b. Mailin		and Number or Rura	l Route Number	, City or Town, Sta	
Z	nd 2 suith ar		Rosalind Steve	ns-Daugh						MD 20906
re,	S 1 a of Hez item		20a. Method of Disposition		20b. Place of Dispos cemetery, cren	natory or other plac	(8)		20c. Location - Cit	
Ë	The state of the s		1 ⊠Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State		Park C		7/05		lle, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-1 show my jury or other traumatic event, Ins Madical Examinat must be natified at once.		21. Signature of Funeral Service Ligens	A	&R 22	Name and Address 246 N.	ss of Facility Sno Washing	owden : ton St	Funeral Rockvi	Home, P.A. 11e,MD20850
龙			23a. Part1. Enter the dise ise, or comp- shock, or heart failure. List only o	cations that caused the cause on each line	ne death. Do not ente					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	1	hmia				Onset and Death
	/Medical		resulting in death)	Due to (or as a						
	Examiner		Sequentially list conditions,	b	6					
- 2,0	Sit ad	Examiner	Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury	Due to jor as a	cons * uence of :					
	and and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physicien and the burial-transit	a E		d						
687	ficate p phys	edical		J						
Box (The law requires that the death certificate has been signed by the attending pipage 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy	Ectopic pregnancy	,		23d. Date of	
	death e atte	lcla	in the past 12 months?	4 Pregnant at til		Other (specify)			Month	Day (ear
P.0	that the de led by the a detached	hys	9 Unknown		46' ' ala		on in Bort I	23a Did to	shacco use contribu	ute to the cause of death?
	res tha igned be del	ρ	Part II. Other significant conditions co	ntributing to death but	not resutting in the u	nderlying cause giv	en in Fait i.			Probably 4 Ponknown
ord	w require been si should b	Completed						24a. Was	-	re autopsy findings available
ec.	e law has b	lg r						autop perfor	sy pric med? dea	or to completion of cause of ath?
alF	icete						26. Place of Deat			Yes 2 No
\frac{1}{2}	sicier certil irecto	9 Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatie	nt 3 DOA Ott	305		lence 6 Other	(Specify)
of	Phy ar this aral d	T: To	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o		ry at	28d. Describe h	now injury occurred	
ion	ath. r: Afte e fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		roar) injury		Yes 2 No			
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (S City or Tox		or Rural Route Number,
Ω	urs at		200 Contine 1 Contituing Ph	ysicien: To the best of	f my knowledge, deal	th occurred at the ti	me, date and place.	and due to the	cause(s) and mann	ner as stated.
	24 ho Funt	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exen	niner: On the basis of and manner stat	examination and/or in	nvestigation, in my	opinion, death occur	red at the time,	date and place, an	d due to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date signed (Month, Day, Year)
	3		Deveny Er	of , M. F.	Ο,	Do	05877C	S	09,11	, 2005
	9		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)	lney, Ma		2-27-	
			Jeremy GRAIZ	18101 Pr	ma Philip	o Dr C	liney, Ma	y land	20832	_
1	S Regis	tate	31. Date filed (Month, Day, Year) SEP 15 20	32 Hegistra	ma Phili	ale				
1.5	I regio	ताचा		NO PERSON	/					

Amend Item State of Mary 1852/ 03/02/08 The Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 13, **Physician** Barry Lee Jones \$eptember 2005 8:27 p. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 1188 Avondale Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 100M 20 F Yrs 53 **Director** 11/26/1951 217-58-2784 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural; or Items 23a or 28a-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Itam 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1188 Avondale Court 21702 U.S.A. Completed by Funeral 12. Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hobart Leon Jones Annabelle Blank ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jones - Wife 1188 Avondale Court, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or 9-16-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Ligensee Maron 1621 Opossumtown Pike, Frederick, Maryland21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** tastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed certificate 1 Yes 2 No Physician: director 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 12 No 2 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours arter user.

To the Funeral Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa nd title of certifier D44184 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederi tohuson Dr. nomes 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per ME, G848, 10/18/05dhb

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per Dr., G848 10/06/05 the eath 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 11, 2005 **Physician** Louise Kirsten 5:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Arbor Crest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Director Dec 4, 1933 112-24-6144 New York Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23a or 28e-f show any injury or other treumetic event. The Madical Enginiting in the notified at once. 10a State 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12801 Old Columbia Pk, #117 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ☐ Yes 27 No Yes, Gîve 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: If Yes, Give Year or Dates: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Schafer Edward Normand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Springbrook Dr. Silver Spring, MD 20904 John Kirsten/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Sept 17, 2005 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Miglin T. Klobert 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Coronary Artery Disease years /Medical Due to (or as a consequence of) Examiner Cirrhosis of Liver years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hemachromatosis CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ♣Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospitel or Attending 1X Natural 5 Pending 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 asvedia D0041173 September 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave, #301, Silver Spring, MD 20902 Martha Saavedra, MD32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 16 2005 Registrar

Division of Vital Records, P.O. Box 68760,

		I _ SIBIO	epartment of Health and Me Certificate of Death		
		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No. 12. Date of Death	No. 3. Time of Death
Physicia	an			Month E	Day Year
/Medic		BURTON SAMUEL KOLKO 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	14 2005 3:00 P M
Examin	er	Washington Adventist Hospital	Takoma Park		Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(av) If Under 1 Year If Under 24 Hrs.	3 Date of Birth	9 Birtholace (State or Foreign
Director		092-30-7431	Months Days Hours Min.	Month, Day, Yea Sept 12,	1939Rochester, NY
P.		Usual Residence of Decedent			
anylar show	h.,	10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
e Ma Ba-1 s	cto	MD Montgomery Takoma	Park		1 ☐ Yes 2 ☐ No
or 2	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
ath v	ral	117 Sherman Avenue	20912		ted States
er de Itemi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 	ify Yes or No- ican, etc.)	 Race - American Indian, Black, White, etc.
be filed within 72 hours after death with the Maryland tal Hygjene. It Hygjene, and the marker of other then "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify: White
tura tura	ed	15. Decedent's Education 16a. De	ecedent's Usual Occupation	16b.	Kind of Business/Industry
nin 72 n "ne	Completed	(Specify only highest grade completed) (C	ive kind of work done during most of working le. DO NOT use retired)	7	
d with piene. r tha	mo	Elementary/Secondary (0-12) College (1-4or 5+) 5 + Juc	lge	F	ederal Government
Hygotha otha	e C	17. Father's Name (First, Middle, Last)	18. Mother's Name (
Alenta Menta rked tic en	<u>е</u>	Isadore Kolko	Miriam Ro	osansky	
shou sand N	_	19a. Informant's Name/Relationship (Type, Print) 19b. N	ailing Address (Street and Number or Rural	Route Number, City	y or Town, State, Zip Code)
and 2 alth a		Linda Kolko, Spouse	7 Sherman Avenue Tal	koma Park	MD 20912
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 271s marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be notified at once.		cometeny	sposition (Name of Da Crematory or other place)	te 20c.	Location - City or Town, State
Page In In In In In In In In In In In In In I		1 XBurial 2 Uremation 3 Linemoval from State	Mem. Gardens 09-16-	-2005 01:	nev. MD
rmit. poartr poorts y inju		21. Signature of Funeral Service Licensee			i Funeral Home, Inc.
88 = 8	2 14	Namany A, Vencen Vis	11800 New Hampshire		
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or head failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
Physician		Immediate Carse (Final disease or condition Cardio-Respirato	rv Failure		Onset and Death
/Medical		resulting in death) Due to (or as a consequence of)			
Examiner		Sequentially list conditions b. Sepsis			
ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
and trans	am	that initiated events c. Advanced Renal C			
cian a		resulting in death) Last Due to (or as a consequence of):			
ficate be executed physician and s the burial-transit	dlcal	d			
leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
Attanding Physician: The law requires that the death certific death: r death. actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
he de	yslo	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (specily)		
that t	'Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
sign sign d be	d by	Ascites		1 🗆 Yes	2 ℃ No 3 □ Probably 4 □Unknown
v requ	Completed			24a. Was an	Oth Mass subsequifications subjects
has be 2	ш			autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
n: Th				1 ☐ Yes AXX	
sicial	Be	25. Was case referred to medical examiner? Hospital: Hospital: 4 Theorem 20 Try/Output	26. Place of Death (
Phy:	1.	1 ☐ Yes 2 ☐ No Tospital 1 ☐ Inpatient 2 ☐ ER/Outpa 27, Manner of Death 28a, Date of Injury 28b, Tim	Mark 30 DOX 40 Noting Hottle	d. Describe how in	6 □Other (Specify)
ding th. : Afte	tlor	1 ဩxNatural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No		.,,
Attan deal ctor y the	flca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm		f. Location (Street a	and Number or Rural Route Number,
after Dira	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ate)
spite nours naral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, an	d due to the cause	(s) and manner as stated.
na Ho n 24 I na Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/c and manner stated.	r investigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)
To tha Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	29c. License number	29d. D	Pate signed (Month, Day, Year)
		Mona Mo.	60999		9/14/01
10		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe. Print)		DC 20012
		Aruna Paspula, M.D., 106 Irving St	reet, NW, Suite #415	, Washing	gton, DC 20010
	5 10	Aluna laspula, nib., 100 11.116 be			
Sta Registr		31. Date filled (Month, Day, Year) SEP 16 2005 32. Registrar's Signature			

			1 - For State of Maryland / Departm	nent of Health and Me cate of Death	ental Hygien Reg. (711115	31833
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		HEUNG SOON KIM	S	September	13 2005	5:45 P ^M
	Examin			City, Town, or Location of Death	4	4c. County of Death	
			2100 Olney Sandy Spring Road, #213	01ney		Montgome	3
	Funeral		1 DM 2 STE		8. Date of Birth (Month, Day, Yea		**
	Director		225.23.7226 79 Yrs. Usuel Residence of Decedent		Sept.22,	1925 Kor	ea
	yland how		10a. State 10b. County 10c. City, Town or Location	n		1	0d. Inside City Limits
	e Mar	Director	Maryland Montgomery Olney				1 X Yes 2 ☐ No
	or 28	Olre	10e. Street and Number	of. Zip Code	10g. (Citizen of What Coun	try?
	ath w	ra	2100 Olney Sandy Spring Road, #213	20832		U.S.A.	
	er de Itama	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. If Yes 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ No.	Decedent of Hispanic Origin? (Spec ., specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Race - Americ Black, White,	
36	irs aff	by F	3 XWidowed 4 Divorced Year or Dates:	es 2⊠ No <i>Specify:</i>		Specify: Asi	.an
9	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-f show the Medical Examination of the motified at	ted	15. Decedent's Education 16a. Decedent's	Usual Occupation	16b.	Kind of Business/Inc	dustry
218	thin 7 e. an "r	Completed	(Specify only highest grade completed) (Give kind life. DO N	of work done during most of working OT use retired)	g		
21	ed wi ygien nar th t, Ille	S		maker		Domestic	
and	2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. I is marked other than "naturel", or trame 23s or 28s-f show raumatic event, tre Medical Exstrict roat be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
ž	hould d Mer marks martic	2	Jae Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	Myong dress (Street and Number or Rural	Soo Hwar	<u> </u>	Code)
Ma	d 2 s th an traul			ar Valley Terrac			
ē,	tam tam		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cremator	(Name of Da		Location - City or To	
9	Page ent of nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Gate of Hea		/2005 Si	lver Sprin	ng, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic events.			ne and Address of Facility S-RINALDI FUNERA			
	99799		Noney H. Vecenty 1180	U New Hampshire	Ave, Silv	er Spring	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or beart failure. List only one cause on each line.	mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) Stomach Ca	ncer			1 year
	/Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of India) that initiated events c.				
o,	an an rial-tr	Еха	resulting in death) Last Due to (or as a consequence of):				
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dicai	d				
9	ertific ding p	Med	IF FEMALE:				
Вох	eath certific attending p for use as	Physician/Me	in the past 12 months?	pic pregnancy		23d. Date of delive Month	ry Day Year
o.	that the de led by the de detached	ysic	1	er (specify)			
Д.	res that igned by be deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco	o use contribute to th	e cause of death?
Records,	requires that een signed b hould be deta	ed by	Anemia, Hypertension		1 🗆 Yes	2 X No 3 ☐ Prob	ably 4 □Unknown
000	aw require s been si 2 should t	Completed			24a. Was an	24b. Were autor	osy findings available inpletion of cause of
	The law ate has b page 2 sl	шо			autopsy performed? 1 ☐ Yes 2 🖾 N	death?	
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death			
of V	95 =	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Hom			9
n c	ing After une	on:	27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	Bd. Describe how inj	jury occurred	
Sic	Attanding r death. actor: After	icat	2 Accident investigation 3 Suicide 6 Could not be		of Location (Street	and Number or Rura	I Pauta Numbas
Division	or Attand after death Diractor: /	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, foulding, etc. (Specify)	ictory, office	City or Town, Sta		noute Number,
_	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investignment of the basis of examination and/or investignment.)				
	To tha H within 24 To tha Fi complete	Aedical	one) and manner stated.				
	To Your	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, L	
,	5		tolenier Minus NiD	D40078	Sep	ptember 15	, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print, Daniel Kim, MD 121 Congression	nal Ln, #318, Roc	rkwilla N	vm 20852	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	lar min, "DIO, ROC	-WATTE !	20032	
	Registr		31. Date filed (Month, Day, Year) SEP 16 2005 32 Registrar's Signature	200			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Walter Victor Kulakowski September 13 2005 7:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 30 Kent Road Earlville Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Director 179-26-5236 71 March 11, PA Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Modeal Executive I intelliged an once. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 YNo MD Cecil Earlville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21919 30 Kent Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Amed Forces:

1 Xi Yes 2 \(\text{No}\)
If Yes, Give
Year or Dates: 1951-54 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Diesel Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Czesław Kulakowski Eleanor Veronica Szymczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Lois Kulakowski/wife P.O. Box 1562, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 09-16-2005 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. * 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, Maryland Suneral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 318 George Street, Chesapeake City, MD ue hang at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on such line. 23a. Part . Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) 2 WKS /Medical Due to (or as consequence of): Examiner slaw will metastassy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit man Chomeuma to (or as a consequ physician s the buriat Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ₩6 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Griffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) JAYAMTILAL LAATELMI) 123514 31. Date filed (Month, Day, Year) State SEP 1 6 2005 Registrar

			For 1 - State Registrar	State o			Dep		of H	lealth a		lental Hy	_	-		318	335
			1. Decedent's Name (First, Middle,	Last)							-	2. Date of D	eath			3. Time	of Death
	Physici		Lilli	an L. KE	LEME	EN						Month Septem	ber 1	13.	2005	9.5	50 A M
	/Medio Examin		4a. Facility Name (If not institution,	give street and nu	mber)			4b. City, T	own, or	Location o	of Death				of Death		<u> </u>
			Hebrew Home of	Greater 1	Wash	ington	L	Ro	ckv	ille			1	Mont	gome	ry	
П	Funeral Director		5. Social Security Number 065–24–2979	6. Sex 1 ☐ M 2 ☐ F	7. Age	(In yrs. last b	irthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of B (Month, D Dec. 1	irth Day, Year)			place (Stat	te or Foreigi
3	2		Usuel Residence of Decedent			40- 0h T											
-	shov	_	10a. State 10b. County			10c. City, To									1		City Limits es 2 ☐ No
2	Ba-f	Scto	Maryland Montgo	mery		Tako	ma	Park					,				
147	Men a	ă	10e. Street and Number	A				10f. Zip (010					Vhat Cour	-	
-	death with the Maryland ms 23s or 28s-f show r must be notified at	Funeral Director	18 Philadelphia	12. Was Dec	adost E	ivor in LLC	12	Was Dasads		912	ain 2 /Cn	anife Van as N			Sta		
_		Ë	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Fo	orces?		13.	If Yes, specif	y Cuba	in, Mexican	, Puerto	ecify Yes or N Rican, etc.)	10-		k, White,	can Indian etc.	1
	irs at	b	3 XWidowed 4 ☐ Divorced	ed 1 □ Yes If Yes, Gi Year or D	ve X Dates:			1 ☐ Yes 2	ONK	Specify:				Specify	wh:	ite	
5	be filed within 72 hours after beath with the Marylar Hygiene. d other then "naturel", or ltems 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent	s Education		16	a. Dece	dent's Usual	Occupa	ation			16b. Kir	nd of Bu	siness/In	dustry	
2	Med "	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-	H)	lite.	kind of work DO NOT use	retired	during mosi d)	t of work	ing					
7	e filed within al Hygiene. I other then " vent, In We	Completed	12				Se	amstre	ss				S	Sewi	ng		
and	d oth	Be (17. Father's Name (First, Middle, L	.ast)								First, Middl		Sumam	е)		
3	should to	2	Jeno Spitz							Mal	vin	Lebov	itcs				
Mar	2 should be and Mental is marked (sumatic ev		19a. Informant's Name/Relationsh	ip (Type, Print)		19	b. Maili	ng Address (Street	and Numbe	r or Rura	al Route Num	ber, City or	r Town,	State, Zip	Code)	
≥ ·	and ealth m 27 her tr		Andrew Kelemen,	Son		1	8 P	hilade	1ph	ia Av	e.,	Takoma	Park	., М	D 20	0912	
5	P it H		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from	State			osition (Name matory or oth				Date			,	own, State	
ׅ֟֞֞֝֟֝֞֟֝֟֝֟֝֟֝֟֟	ien ii.		* 4 □ Donation 5 □ Other (Sp	ecify)		Metro	pol	itan C	rem	atory	09/	14/05	Alex	cand:	ria,	VA	
Baltimor	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service L	icen e	-		T	2. Name and Drchin	Addres SKy	ss of Facilit Hebr	ew F	uneral	Home	2			
_			1000				2	54 Car	ro1	1_St.	, NW	, Wash	ingto	n,	DC 2	20012	
			23a. Part1 Enter the disease, or shock, or heart failure. List of	complications that only one cause on a	each line	the death. Do	not en	ter the mode	of dyin	g, such as	cardiac o	or respiratory	arrest,			Approxin Interval 8 Onset ar	Between
F	hysician		Immediate Cause (Final disease or condition	_a. A+	han	oler	cho	he	a. "	+ 41	isea	1e				Orisot ai	d Death
	/Medical Examiner		resulting in death)	Due to	(or as a	consequence	9 of):								1		
		Ļ	Sequentially list conditions,	b. — Due to	/or or o	000000000000	o of):										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to	(or as a	consequence	e or):										
	be executed ician and burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a	consequence	e of):								-		
/6U,	e be executed /sician and e burial-transit	caiE			(,-										
20				d													
×	leath certificate attending phy i for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome c	of pregnancy								23d Date	e ol delive	20/	
ž pox	death e atten ed for u	ciar	in the past 12 months?			2 ☐ Fetal deat time of death		∃Ectopic pre ∃ Other <i>(spe</i>						Mor		Day	Year
ָ יָכ	E E	Jysi	9 Unknown	9□ Unkn	nown												
ς, L	w requires that been signed b should be deta	by P	Part II. Other significant condition	ns contributing to d	leath bu	t not resulting	in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco u	se contr	ribute to th	ne cause o	of death?
g .	quire n sig nd bu	d b										10	Yes 2	J10	3 🗆 Prob	ably 4	□Unknown
ပ	> 0	Completed										24a. Wa		24b. V	Vere auto	psy findin	gs available
r,	age	E										perl	opsy formed?	d	leath?	mpletion o 2□ No	it cause of
	certifical	Be C	25. Was case referred to medical							26 Place	of Death	1 Yes	2□No	1	☐ Yes	2U NO	
<u> </u>	ysicien: nis certifica director,	.0	examiner? 1 Yes 2 No	Hospital:	Inpatier	nt 2 ER/C	Outpatie	nt 3 🗆 DOA	Othe		,	me 5□Res		3 ∏Othe	er (Specif	v)	
0	g Ph ter th	n: T	27. Manner of Death	28a. Date (Mor	of Injun	y 28b.	Time o	1 28	c. Injury Work			28d. Describe				, ,	
<u></u>	uttending I death. ctor: After y the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		in, ouy	r dar)	milary	М		Yes 2 □ i	No						
DIVISION	0.0	tific	3 Suicide 6 Could n 4 Homicide determi	ned 288. Place	e of Inju	ry - At home, : (Specify)	farm, st	reet, factory,	office			28f. Location City or To	(Street and own, State)	d Numbe	er or Rura	I Route N	umber,
5	talor rsafte al Diu	Certification:				. (0,000.1)							, σιαιο,	,			
Ì	To the Hospital of within 24 hours at To the Funeral D completely filled in	cai	(Check only 2 Medical 8	Physicien: To the Examiner: On the b	e best o	f my knowledge examination a	ge, deat	h occurred a	t the tim	ne, date an	d place, th occurr	and due to the	e cause(s)	and mai	nner as s	tated.	A(S)
	To the h within 24 To the P complete	Medical	Unite)	and mar	ner stat	led.											
- 1		2	29b. Signature and title of certifier	1 -						e number						Day, Year	
U	2		Jany 3	will		a			12	272			Septe.	mhe	13, 2	005	,
			30. Name and address of person v	who completed cau	se of de	ath (Item 23a		n	/	Poc Ku	11-	tu I		2	100 m	005	
			31. Date filed (Month, Day, Year)	32 5	Andistra	r's Signature		load	- 1	100 200	16	May	en d	600			
	Sta Regist		SEP 1	5 2005 A	1081A	r's Signature	A	parte									
				1000	An Alban		-										

			For State Registrar		State of Ma	aryland	/ Depa	artme <i>rtifica</i>	nt of Hea <i>te of De</i>	alth and I eath	Mental Hy	gien Reg. N	2005	31836
*	Physici	an	1. Decedent's Name (1)						2. Date of De	eath	ay Year	3. Time of Death
	/Medic	cal	Emilie M.								Septem	ber 1	2, 2005	8:05 p.m. M
	Examin	ier	4a. Facility Name (If n Shady Grove	Adventist	Hospital				ckville	cation of Deati	1		c. County of Dea Contgonery	
	Funeral Director		5. Social Security Nun 578–28–7947		7. Ag	e (In yrs. las 81	t birthday) Yrs.	If Und Months		Under 24 Hrs. Hours Min.	8. Date of Bing (Month, Do	rth ay, Year B, 192	9. Bir Co 24 Ala	thplace (State or Foreign buntry)
	pug 🖈		Usual Residence of D	Decedent 10b. County		10c. City, 1	Tour or Lo	antina						
	ith the Marylar or 28e-f show	ro		Prince Geo	rope's	-	ville	Cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28e	irec	10e. Street and Numb					10f. Z	ip Code			10g. C	citizen of What Co	
	23a c	rai D	4302 Birmin	gham Place				20	705			U	hited Stat	tes
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show among injury or other treumatic event, its Midical Exaciter mast be mailised at once.	by Funeral Director	11. Marital Status 1 □ Never Married 3 🎗 Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 Mill Yes, Give Year or Dates:	Ever in U.S. No			3.2	anic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
2-0	72 hou	ted	/Specific	5. Decedent's Ed only highest grad	ucation		16a. Deced	dent's Us	ual Occupatio	n	aleta –	16b. I	Kind of Business	/industry
21215-0036	vithin 7	Completed	Elementary/Second	lary (0-12)	College (1-4or 5	5+)	life. L	DO NOT	use retired)	ng most of wor	King			
	filed v Hygie ther t		17. Father's Name (Fi	12 irst, Middle, Last)	1–4		Accui	шу	Assista		ne (First, Middle		riott Con	poration
ılan	Juid be Jental rked c	To Be	Erwin Mar							Vora Fay		,		
, Maryland	and 2 should be filed within alth and Mental Hygiene. 127 is marked other then "er treumatic event, It e Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men		19a. Informant's Nam Steven A. Ki				19b. Mailin 17420	ng Addres M oni t	s (Street and or Drive	Number or Rue Olney,	ral Route Numb Maryland	er, City 2083	or Town, State, 2	Zip Code)
ore	of He		20a. Method of Dispo		Removal from State	cem	e of Disponetery, cren	natory or	other place)		Date	20c. l	Location - City or	Town, State
Baltimore,	thent of thent if it		`4 □Donation 5	Other (Specify	4	Metr			ematory	9/17/			xandria, V	
Bal	permi Depa Impo any ir		21. Signature of Fund	Im	Mark	the same	-\frac{13}{4}	offic 400 F	owder Mi	wardt Fu 11 Road	neral Hor Beltsvill	e, P e, M	.A. aryland 20	705
П					lications that caused one cause on each lin	the death. I	Do not ente	er the mo	de of dying, s	uch as cardiad	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)	inai	a. Acute			ure						Orisot and Doalin
	Examiner				Due to (or as Multip			ailu	re					
	₽ #	ner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	ditions, nediate	Due to (or as									
	and -trans	Examiner	Cause (Disease or in that initiated events resulting in death) La		c. Lung (
68760,	tificate be executed ig physician and as the burial-transit	aiE		•	d	a consequer	ice oi).							
	tificate ng phy as the	fedical		-	d									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 V	onths?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	eath 3	Ectopic Other (s	oregnancy specify)				23d. Date of del Month	ivery Day Year
Δ.	res that igned by		Part II. Other signification	ant conditions co	ntributing to death b	ut not resultin	ng in the ur	nderlying	cause given in	n Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?
ords	w require been sig should b	ted t	Sepsis; C	HF							1 🗆	Yes 2	2□No 3□Pr	obably 4X Unknown
Records,	hysicien: The law n his certificate has be il director, page 2 sh	Completed by										psy ormed?	prior to death?	topsy findings available completion of cause of
Vital		Bec	25. Was case referred examiner?	d to medical					26	3. Place of Dea	1 ☐ Yes	2(z N one)	0 10108	2 No
of V	Physicien: r this certific ral director,	0	1 Yes 2 No	0		ent 2 ER				4 🗌 Nursing H			6 Other (Spec	pify)
on (ding F h. After funer	tion		5 Pending investigation	28a. Date of Injur (Month, Day	ry y Yea <i>r)</i> 28	Bb. Time of Injury	м	28c. Injury at Work?	2 🗆 No	28d. Describe	how inju	ury occurred	
Division	l or Attendii after death. Director: A I in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	286. Place of Inju	ury - At home	e, farm, stre			2 110				ıral Route Number,
Ö	tel or rs afte el Dire	Cert		40	building, etc						City or To			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination	edge, death and/or inv	occurred	at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s date an	s) and manner as nd place, and due	stated. to the cause(s)
	To the To the comp	Ž	29b. Signature and tit	le of certifier	/ u.	/\		29	c. License nu				ate signed (Monti	
•	10		1	m ?	000				מטטת	1 J L 4		sep	otember '	13, 2005
_			30. Name and address Aiping St	is of person who c	9901 Medi	eath (Item 23 .cal Ce	3a) (Type, 1 enter	Print) Dri	ve Rock	wille.	Marvla	nd 2	20878	
	Sta Registr		ST. Date filed (Month),	Day, Year) P 1 5 20	SZEJTOGISTI	ar's Signature	B Sou	enti)						

3	8	3	7
_	_	_	

			1 - For Amend Item 1 Registrar		0-24-05 Cei	tas tificate of D	Death			
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	Day Year	3. Time of Death
	/Medic		Nathan Larkir 4a. Facility Name (If not institution, giv			4b. City, Town, or I	ocation of Death	SEPT.	14, 2005 4c. County of Death	0643 A [™]
	Examin	ıer	PRINCE GEORGES H			CHEVERL			PRINCE GEO	RGES
I	Funeral Director		579-06-1583	7. Age (In yrs. 25	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7/17/80		place (State or Foreign htry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation	,		1	0d. Inside City Limits
	Mary III	tor	D.C.	Wa	ashingt	on				1X Yes 2 ☐ No
	th with the 23a or 284	ai Director	10e. Street and Number 2203 Rand Place	N.E.		10f. Zip Code	20002	1	0g. Citizen of What Court U.S.A.	ntry?
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or liems 23a or 28a-f show avent, I've Medical Exam our must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban □ Yes 21X No	spanic Origin? (Spe i, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
5	72 h	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	lent's Usual Occupat	uring most of working	ng	16b. Kind of Business/In	dustry
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired) borer			Private Inc	histry
2	filed v Hygie other f	e Co	10th 17. Father's Name (First, Middle, Last)	Lic		18. Mother's Name			lustry
a	lid be lental ked c	To B	Nathaniel Ware				Rose	y Larkin	ns	
Mary	ges 1 and 2 should be filed v it of Health and Mental Hygie If Item 27 is marked other t or other traumatic svent, In		19a. Informant's Name/Relationship (Rosey Larkins/Mo		19b. Mailir 2203	g Address (Street at Rand Pl.,	N.E., Was	al Route Number shingtor	, City or Town, State, Zip 1, D.C. 20002	Code)
Baltimore, Maryland 21215-0036	Pages 1 e nent of Hei int: If itsm iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crer	sition (Name of natory or other place)		20c. Location - City or To	
att	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee		Name and Address H.S.Washi				
	40 E 3 G		dany n	: Grau	49	25 Nannie	H. Burro	oughs Av	re.N.E.Was	
	Physician /Medical Examiner		Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	2 QU	U2 Not			951,	Approximate Intervat Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	quarico JI).					
68760,	ficate be executed physicien and is the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consec	quence of):					
_			IF FEMALE:	23c. If yes, outcome of pregn	2001					
P.O. Box	the death certifi y the attending iched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	The law requires that the death cert Ne has been signed by the attending page 2 should be detached for use a	ğ	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause give	n in Part I.	23e. Did tot	oacco use contribute to these 2 XNo 3 □ Prot	ne cause of death?
Division of Vital Records,	The law re ete has ber page 2 sho	Completed						24a. Was a autops perform	ned? prior to co	psy findings available mptetion of cause of 2 No
<u>ita</u>	cisn: ertific ector,	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only on	θ)	
 	Physi this c al din	2	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2X	ER/Outpatier		4 Nursing nor		ence 6 Other (Specification) occurred	y)
sion	Attending Physicism: ir death. ector: After this certification is the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	n 9-14-00	28b. Time of Injury	M 1□Y	es 2 No	Sulpi	ject she	
<u>N</u>	ospitel or At hours after o uneral Direc ly filled in by		4 Apmicide determined	building, etc. (Speci	mpour!	Ling lo	+	City or Town	Heren Koke	[3.E.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Example)	nysicien: To the best of my kniminer: On the basis of examination and manner stated.	owledge, death ation and/or in	r occurred at the time restigation, in my opi	inion, death occurre	ed at the time, da	ate and place, and due to	the cause(s)
-	5 ₹ 5 g		29b. Signature and title of certifier	aus - F	elle.	0.	C.M.E		9d. Date signed (Month, SEPT. 15,	* -
2	12/		30 Name and address of person who	Ironica-Kalat	11 PENN	Print) I STREET,	BALTIMOR	E,MARYLA	ND 21201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 6 20	33 Registrar's Sign	A Spa	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes - State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 15, 2005 12:41A M Eileen Lazar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | FEB. | 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 → F New York Director 062-26-2189 71 Yrs. Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Exeminer must be notified at 1 Yes 2 □ No Director Maryland Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12312 Overpond Way 20854 United States of America filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced "natural", Completed 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Coat and Outerwear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any injury o<u>r otha</u>r traumatic event Be Dora Weinstock Benjamin Pianin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12312 Overpond Way, Potomac MD 20854 Lawrence G. Lazar - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ARemoval from State Cedar Park Cemetery 09/17/05 Emerson, New Jersey *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Danzansky Goldberg Memorial Chapel, Inc. Donald *1170 Kockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the softh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) 5 Months Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate To the Hospital or Attending Physician: Director: After the in by the funeral death. filled in by within 24 hours efter To the Funeral Dire

Baltimore, Maryland 21215-0036

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/15/03 54375 Dur

State

Registrar

31. Date fited (Month, Day, Year) 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			For State	State of	f Maryland		artment o			and M		_	2000		016	200
			Registrer 1. Decedent's Name (First, Middle	Last)		Cer	uncate	טוט	ealli		2. Date of Dea	Reg. Not	2000		3. Time of	Death Death
	Physicia		JOSEPHINE	MARY	LAUE					S	Month SEPTEMB	ER 1		r	2:30	
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, To	wn, or L	ocation o				. County of De			
			10019 PORTLAND						SPRI				ONTGOME			
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21/2 F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months	ear ays	Hours 1	Min.	8. Date of Birt (Month, Da	v. Year)	9. 8	irthplac	e (State o	r Foreign
	Director		578-40-5580 Usual Residence of Decedent		75				1	4	APRIL 1		1930 W	ASHT	NGTO	N, DC
	nyland how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d.	Inside Ci	
	se Ma Sa-f s	cto	MARYLAND MONTGO	MERY		SILVER	SPRIN								1X Yes	2 🗆 No
	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f show the Medical Examiner must be notified at	Funeral Directo	10e. Street and Number	OAD			10f. Zip Co		1				izen of What (,		
	eath	erai	10019 PORTLAMD R		edent Ever in U.S	S. 13.V		090		nin? (Sper	cify Yes or No		TED ST			
(0	riter d	Fun	1 ☐ Never Married 2K Marri	Armed Fo	rces? 2∭No					, Puerto F	cify Yes or No- Rican, etc.)		Black, Wh			
5-0036	rei', o	1 by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	re ates:		I⊡Yes 2🔀	No	Specify:				Specify:	WHI	TE	
2	72 h "natu	Completed	15. Decedent (Specify only highes	s Education ! grade completed)		(Give	lent's Usual C kind of work	done du	ion iring most	of workin	g	16b. Ki	ind of Busines	s/Indus	try	
7	within ene. than	dwo	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life. L	OO NOT use NURS					NT	RSING			
р Б	filed Hygid other		17. Father's Name (First, Middle, I	.1			TIORE		18. Mother	r's Name	(First, Middle,					
an	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "naturel", or lieme 23e or 28e-f show marked other than "naturel", or lieme 23e or 28e-f show imatic event. Its Medical Examinat must be retified at	To Be	MICHAEL	BENEDIKT					II	RMA		WU	JNDER			
Maryland 2121	2 should and Men is marke eumatic		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (S	treet an	nd Numbe	r or Rural	Route Numbe	r, City o	r Town, State	Zip Co	de)	
	1 and 2 Health sem 27 is		GERHARD W. LAUE	, HUSBAND					ROAI		LVER S				901	
altimore,	Pages 1 nent of H. Int: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from	State C6	metery, cren	sition (Name natory or othe	r place)	- 1		ate		ocation - City of			
≣	permit. Pag Department Important: i any injury o		`4 □Donation 5 □ Other (Sp		GATE		STATE OF THE PARTY AND ADDRESS OF THE PARTY AN	residence will be about the			7/2005				, MA	RYLAN
Bal	permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is marked any injury or other treumatic evense.		21. Signature of Funeral Service I	. Litor	themes	2 - 10	91 ROC	KVI	LLE I	PIKE.	DIREC ROCKV	ILLE	I, INC.	208	52	la la
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the dath	. Do not ente	er the mode o	f dying,	such as o	cardiac or	respiratory ar	rest,		Int	proximate terval Betw nset and D	ween
E	Physician		Immediate Cause (Final disease or condition resulting in death)	a. METAS	STATIC C	ARCINO	MA OF	THE	LEFT	r bre	EAST				YEAF	
	/Medical Examiner		resulting in death)	Due to ((or as a consequ	ence of):										
		ē	Sequentially list conditions, if any, leading to in rediate cause. Enter Underlying Cause (Disease or injury	b. — Dua to ((or as a consequ	unga of):								-		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												3
o,	e exectan and and arrial-to	Ex	resulting in death) Last		(or as a consequ	ence of):										
8760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dicai		d.												
9 xo	eath certific attending p for use as	/Med	IF FEMALE:	23c If yes out	come of pregnar	ncv						1	004 5-144			
Bo	atten atten	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	oirth 2 ☐ Fetal	death 3	Ectopic pregi					1	23d. Date of d Month	Da	y Y	'ear
o.	that the de ad by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	own											
ď.	res that igned be be det	by P	Part II. Other significant condition	ns contributing to de	eath but not resu	lting in the ur	nderlying caus	se given	in Part I.		23e. Did to	bacco u	ise contribute	to the c	ause of d	eath?
ğ	w require been sig should b										1 🗆 Y	es 2	X No 3 □ 1	Probably	y 4 □U	Inknown
ecords,	ne law re has be ge 2 sh	Completed									24a. Was autop		24b. Were a	autopsy comple	findings a	available ause of
<u>ح</u>		Con									perfor		death?	s 2] No	
Vital R	iyeician: Th	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o					
	S = 1	T	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date	Inpatient 2 E	R/Outpatien 28b. Time of		Injury a			e 5 Resid			ecify)		
on	nding Phy th. : After this s funeral o	tion	1 X Natural 5 ☐ Pending investig	(Mont	th, Day Year)	Injury	М	Work?	es 2∐N			, , ,	,			
Division of	or Attendiater death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At hor	me, farm, str	eet, factory, o	ffice		2	8f. Location (S City or Tow	treet an	d Number or I	Rural Ro	oute Numi	ber,
	rs after ei Direc ed in by	Cert				_							,			
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physicien: To the Examiner: On the ba and mann	best of my know asis of examinati ner stated.	vledge, death ion and/or inv	occurred at the occurred of th	he time my opir	, date and nion, deat	d place, a h occurre	nd due to the o d at the time, o	ause(s) late and	and manner a place, and du	as stated ue to the	d. e cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0			29c. L	icense r	number			29d. Dat	e signed (Mor	nth, Day	, Year)	
	10		James G	12100	ou d	W	D07	285				SEPT	EMBER	15,	2005	5
	U		30. Name and address of person v													
	- 0		JAMES A. BROWN, 31. Date filed (Month, Day, Year)	204	Anintrada Cianat	150		RIV	E, RO	OCKVI	LLE, M	ARYL	AND 2	0850)	
	Sta Registr		SEP 16	2005	gues B	Gos	will !									

		•	For State Registrar	licase	State of N	/larylan	d / Dep	artment of rtificate or	Health a	nd Mental Hy	giene (05	31840
	Dharaini		Decedent's Name (First	t, Middle, La	ast)					2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medio		Irving Wi							Septem	ber 18	2005	4:30 P M
	Examir	er	4a. Facility Name (If not in			r)		4b. City, Town,		Death		ty of Death heste	
	Euperal		Mallard Bay 5. Social Security Number			Age (In yrs.	last birthday	Cambrio	r If Under 24	4 Hrs. 8. Date of Bi			
	Funeral Director		212-16-1579 Usual Residence of Dece		1 X 2 M 2□F	90		Months Day	s Hours	Min. (Month, Da Sept.	rth ay, <i>Year)</i> 15 , 1915	Mar	place (State or Foreign ntry) "Yland
5	ryland			County		10c. Cit	ty, Town or L						10d. Inside City Limits
2	Be-f s	cto		Dorche	ester				ngate				1 ☐ Yes 2 XNo
9	with the	Funeral Director	10e. Street and Number 2161 Wing	ate R	ishons Hea	ad Bos	d	10f. Zip Code	21675		10g. Citizen o		intry?
0	Jeath ms 23	erai	11. Marital Status	<u> </u>	12. Was Deceder	nt Ever in U		Was Decedent of		n? (Specify Yes or No Puerto Rican, etc.)			ican Indian,
920	urs after o	þ	1 Never Married 2 3 Widowed 4 D	-	Armed Force 1 XYes 2 [If Yes, Give Year or Dates] No T.₩.7.T		If Yes, specify Cu 1 ☐ Yes 2 💢 N		Puerto Rican, etc.)	Spec	ack, White,	ite
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or itsms 23a or 28e-1 show any injury or other traumatic svent, the Medical Examiner must be notified at ance.	Completed			ducation ade completed) College (1-4d	r 5+)	16a. Dece (Give life.	dent's Usual Occ kind of work don DO NOT use retii	upation e during most of red)	of working	16b. Kind of	Business/Ir	ndustry
21	ed with	Corr	11					mechar			food 1		ssor
nd	be file tal Hy d oth	Be	17. Father's Name (First,		t)					s Name (First, Middle		ime)	
∠a	Men Marke Matic	2	Asbury M.		(Town Bright)		105 14-75			Pritchett			0.77
Mai	d 2 st th and 7 is n traun		19a. Informant's Name/R Barry Lew		. ,.	.				or Rural Route Numb		ı, State, Zij	o Code)
	Healt Healt tem 2	1 1	20a. Method of Dispositio	n	so	20b. F	Place of Dispo	sition (Name of	- !	aford, DE	19973 20c. Location	- City or T	own, State
OF.	ages ant of nt: if if		1 Surial 2 □ Cre 1 Donation 5 □ 0			(0	,	matory or other p Veterans	·	9/21/05	Hurloc	ъ мг	
Baltimore,	mit. F partme orter injur		21. Signature of Funeral			rkar		2. Name and Add					
ä	Per in Ca		Brue K	· Bu			7	00 Locus	st St.,	Cambridge		1613	
760,	be executed /Medical Examiner	cal Examiner	23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(a. Cor a Due to (or a Due to (or a	as a conseq C + c	uence of):	r acc					Approximate Interval Between Onset and Death
P.O. Box 687	Attending Phyelcien: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregint the past 12 montf 1 Yes 2 No 9 Unknown		d. 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3[□Ectopic pregnan □ Other (specify)	су			ate of deliv	ery Day Year
	uires that signed to ld be deti		Part II. Other significant	conditions	contributing to death	but not res	ulting in the u	inderlying cause g	jiven in Part I.				he cause of death?
Division of Vital Records,	ding Phyelcien: The law requir n. After this certificate has been s funeral director, page 2 should	Completed									an 24b psy prmed? 2 No	Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to examiner?	medical	Hospital:			_ 0	thor /	of Death (Check only o			
to.	Phye r this ral di	5. To	1 Yes 2 No		I 🗀 Impa		28b. Time o	nt 3 DOA	4 Nurs	sing Home 5 Resi	dence 6 🗆 Ot how injury occu		(y)
lon	nding R th. : After e funer	tlor	1 ☑Natural 5 ☐ 2 ☐ Accident	Pending investigation	28a. Date of Ir (Month, L	Day Year)	Injury	W	onk? ⊒Yes 2.⊟No	0			
Divisi	ol or Atter after dea i Director d in by the	Certification;		Could not to	286. Place of I	njury - At ho etc. <i>(Specif</i>	ome, farm, st	reet, factory, office	Э	28f. Location (City or To		ber or Rura	al Route Number,
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the f	edical C	29a. Certifier 1 0 (Check only one)	Certifying P Medicel Exa	hysician: To the bearings: On the basis and manner	of examina	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and n date and place	nanner as s , and due t	stated. o the cause(s)
	within To th comp	Me	29b. Signature and title o	f certifier	O H				nse number		29d. Date sign		Day, Year)
				Shure	The MD			04	7924	1	9.1	7-05	
			30. Name and address of	person who	_	death (Item	1 23a) (Type,	Print)	or Risk	n mp	210	513	
	Sta Registi		31. Date filed (Month, Da	у, Year) БР 2 (strar's Signa	ture	bote					

			Charles of Mandand / December 1864 -
			State of Maryland / Department of Health and Mental Hygiene 1- State Certificate of Death
			- Registrar Continuate of Death Reg. No
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	/Medi		George Washington Lee Sept. 16, 2005 1150 M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death
			Dorchester General Huspital Cambridge Dorchester
	Funeral		5. Social Security Number 217-07-3773 6. Sex, 12 M 2 F 7. Age (In yrs. last birthday) 12 M 2 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. April 3, 1913 9. Birthplace (State or Foreign Months) 12 M 2 F 7. Age (In yrs. last birthday) 12 M 2 F 7. Age (In yrs. last birthday) 13 M 2 F 7. Age (In yrs. last birthday) 14 M 2 F 7. Age (In yrs. last birthday) 15 M 2 F 7. Age (In yrs. last birthday) 16 M 2 F 7. Age (In yrs. last birthday) 17 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 19 M 2 F 7. Age (In yrs. last birthday) 19 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 10 M 2 F 7. Age (In yrs. last birthday) 11 M 2 F 7. Age (In yrs. last birthday) 12 M 2 F 7. Age (In yrs. last birthday) 13 M 2 F 7. Age (In yrs. last birthday) 14 M 2 F 7. Age (In yrs. last birthday) 15 M 2 F 7. Age (In yrs. last birthday) 16 M 2 F 7. Age (In yrs. last birthday) 17 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 7.
	Director		Usual Residence of Decedent
	and w		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
-h	Many f sho	ō	100
7	28a 19	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
7	WIE OF	۵	
32	ms 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
•	iter o	틆	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ② No 1 □ Never Married 2 □ Married 2 □ Married 1 □ Yes 2 ② No
93	urs a	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify: Specify: Specify:
5-0036	/2 hours after natural', or ite ical Erando	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	within / iene. than "n the Med	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)
21	giene er the	Ю	5 Processing Line Worker Seafood Industry
	be tile ital Hy id othe event,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
<u>a</u>	iould be filed with Mental Hygiene narked other thai natic event, the h	To E	Jonah Lee Annie Kane
<u> </u>	and h	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	permit. Pages I and 2 should be filed within 72 hours affer death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in Important: It flom 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Martical Examination at collish at any injury or other traumatic event, the Martical Examination of the rediffical at once.		George Lee 816-Robbins Street Cambridge, MD. 21613
Φ.	of He	0.3	20a. Method of Disposition (Name of Date 20c. Edition - City or Town, State
Ĕ	Pages net of int: If it		1 to Burial 2 Cremation 3 Hemoval from State Sun Ha Civil Connection 1 9/24/05 Taylors TS/020 MD
atti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY FUNERAL HOME, P. A. 510 Washington St. Cambridge, MD. 21613
m	Depa Impo any is		Janelle C. Henry Henry Funeral Home, 1. 1.
	1		23a. Part 1. Enter the disease, or complications that caused the flath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between
100	hysician		Immediate Cause (Final Onset and Death
2	/Medical		disease or condition resulting in death) a. Due-to (or as a consequence of):
8	Examiner		A Colidure of Atto
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Sue to (or as a consequence of): Cause (Disease or injury that initiated events c.
	outed od ransii	Examiner	Cause (Disease or injury that initiated events
ó	re be executed ysician and re burial-transit		resulting in death) Last Due to (or as a consequence of):
760,	inal the beath certificate be executed ed by the attending physician and detached for use as the burial-transit	ical	d
68	ng pt as th	Physician/Med	TE SERVICE
Вох	endii r use	an/A	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery
Ξ.	ne att ed fo	Sicie	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)
P.0	by the	hys	9 Unknown
Ś	The raw requires that the beam bertillica ate has been signed by the attending ph page 2 should be detached for use as th	by F	Part II Other significant conditions contributing to death but net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
p	been si should t	ed	Kesting Ladure Janeatia Stay1741its 1 Yes 2 No 3 Probably 4 Bunknown
Records,	aw requ	plet	Hy Decly Sich Revail Feetling 24a. Was an 24b. Were autopsy findings available
H ;	ite hä	Completed	autopsy performed? performed? death?
		BeC	25. Was case referred to medical 26. Place of Death (Check only one)
>	V) T)	ToB	examiner? 1 Yes 2 No
	After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Division	Attending r death. ector: After by the funer	atlo	2 \(\text{Accident} \) investigation \(\text{M} \) 1 \(\text{Yes} \) 2 \(\text{No} \)
Vis	after death. Director: A	ific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	s affe	Certification:	building, etc. (Specify)
	within 24 hours after deal To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my onlying death occurred at the time, date and place, and due to the cause(s)
3	in 24 in 24 he Fi	Medical	one) and mapping stated.
F	To t	Σ	29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Dey, Year)
•			Tais a / a 10, H44615 9/16/05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			14015 A. MARR U.O. 100 WARMALL BY CAMBRIDGE
¥	Sta		31. Oale filed (Month, Day, Year) 32. Registrar's Signature
	Registr	ar	Stefan De Sperke

GEORGE LEE

State of Maryland / Department of Health and Mental Hygier $\stackrel{\bullet}{p}$ 0 0 531842 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** Svlvester Rav Lepley SEPTEMBER 20TH, 2005 15:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ALLEGANY MEMORIAL HOSPITAL CUMBERLAND
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Mar 30, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Yrs 79 Director 220-16-6482 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 27 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Allegany MD Cumberland 1 Ves 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 Cumberland Manor Apts # 607 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any Injury or other treumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: þ 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah (Lewis) Lepley Rister Lepley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Bennett sister 428 Walnut Street Cumberland MD 21502 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sunset Memorial Park 9/24/2005 MD Cumberland 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} Scarpelli Funeral Home, PA 21. Signature > Funeral Service Licens 108 Virginia Avenue: Cumberland, MD 21502 Finiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician -ymphama lanom disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit law requires that the death certificate be exacuted Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Alcoholism 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 200 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 🗌 Yəs 2 ER/Outpatient 3 DOA 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 16 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ne Funarai C 29a Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 20105 D60478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFAQ, KENT AVENUE. AHMAD, M.D. SUITE 102, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 2 9 2005 Registrar

		1	For State Registrar	State	of Maryland	•	rtment of He			giene	1115	318	143
			Decedent's Name (First, Middle,	Last)					2. Date of Dea			3. Time o	f Death
	iysicia Medic		MA	ARK	L	ANGSAI	1			BER :	12, 2005	10:05	5 A M
	kamin	er	4a. Facility Name (If not institution,				4b. City, Town, or L				County of Death		
			10401 GROSVENOR 5. Social Security Number	PLACE, 1	7. Age (In yrs. las	t hirthday)	N. BETHES	SDA If Under 24 Hrs.	8. Date of Birt		ONTGOMER	·	or Foreign
	neral ector		131-30-6858	1 ∑ M 2□F	64	V	Months Days	Hours Min.	(Month, Da	y, Year)	940 New	lace (State of try) York	or r or orgr
	.0101		Usual Residence of Decedent						Берс. 2	- 7 , 1			
arylar	퍰	_	10a. State 10b. County		10c. City,	Fown or Loc	cation				1	0d. Inside C 1 ☐ Yes	ity Limits 2 ☐ No
the Mi	all l	Director	Maryland Monte	omery_	N. H	Bethes	10f. Zip Code			10a. Citiz	zen of What Cour	X	
with	ther		10401 Grosvenor	Place.#	802		20852-46	35			5. A.	,	
death with the Maryland ms 23a or 28a-f show	T-MIS	Funeral	11. Marital Status		edent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cuban		ecify Yes or No		14. Race - Americ Black, White,		
atter	曹		1 Never Married 2 X Marrie	d 1 XYes	2□No Navy	7 1	_	Specify:	nican, etc.)		Specify:		
within 72 hours after ene.	Exa	d by	3 Widowed 4 Divorced	Year or I	Dates: Vietna	am						WHITE	
n 72	ollic	lete	15. Decedent's (Specify only highest	grade completed)	(Give life. L	ent's Usual Occupat kind of work done du OO NOT use retired)	iring most of work	in g	100. KII	nd of Business/Ind	uusuy	
J with Jiene.	Te N	Completed	Elementary/Secondary (0-12)	College 5+	(1-4or 5+)	Ecor	nomist			G	S A		
VIATIO CICI. Suld be filed within 7 Mental Hygiene.	event, the Madical Examiner must be notified at	Bec	17. Father's Name (First, Middle, L	ast)				18. Mother's Name	e (First, Middle,	Maiden	Sumame)		
2 should be and Mental is marked	atic	To	Alexander E.						nce Gott				
Mar d 2 sh th and th and	traum		19a. Informant's Name/Relationsh Jude K. Langsam		10.0		g Address <i>(Street</i> ar Grosvenor						20852
an an	other		20a. Method of Disposition	 	20b. Plac		sition (Name of patory or other place,		Date		cation - City or To		20032
nol pages ant of	30		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1 State		Cemetery	9/14/	2005	Rock	cville, N	arv1a	ınd
baltimore permit. Pages 1. Department of He	iniu e	Ì	21. Signature of Funeral Service L		1 - 1		Nama and Address		The second secon			-	
	e 8) Donald (. Mo		ル 11	70 ROCKVII	LLE PIKE	, ROCKV	ILLE	, MD 20	852	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of						or respiratory a	rrest,		Approxima Interval Be Onset and	tween
Priysi			Immediate Cause (Final disease or condition resulting in death)	_ a			tive Disc	rder			N N	lonths	
/Med Exam	dical niner		(County)	Due to	o (or as a conseque	nce of):							
	OX.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a conseque	nce of):							
ponted	ransit	Examiner	that initiated events	c									
e exe	urial-t		resulting in death) Last	Due to	o (or as a conseque	nce of):							
. BOX 68/60, death certificate be executed	priysician and the burial-transit	dical		d									
OX 6 h certitic	attending p	/Me	IF FEMALE:	23c. If yes, o	utcome of pregnanc	у				2	23d. Date of delive	ery	
Beath Geath	d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	birth 2 ☐ Fetal d gnant at time of dea		Ectopic pregnancy Other (specify)				Month	-	Year
at the c	signed by the signed be detached f	hys	9 Unknown	9∐Unk	nown			_					
S, T	gened be de	by P	Part II. Other significant conditio	ns contributing to	death but not result	ing in the ur	nderlying cause giver	n in Part I.		1102	se contribute to the		
Ord requir	pluods								10			ably 4	
Records, P.O. The law requires that the	2 2	Completed							24a. Was autopento		24b. Were auto prior to co- death?	psy findings mpletion of	available cause of
	Da o	e Col	25. Was case referred to medical					26. Place of Deat	1 ☐ Yes	2 X No	1 🗆 Yes	2 No	
	rnis certifica ral director, p	0 B	examiner? 1 Yes 2X No	Hospital: 1	Inpatient 2□El	R/Outpatien	Other	r			6 ☐Other (Specif	v)	
DIVISION OF I or Attending Physical death.	er this	-	27. Manner of Death	28a. Dat		8b. Time of Injury		at	28d. Describe			,,	
endin eath.	or: All	satlo	1X Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation			M 1□Y	es 2 🗆 No		_			
or Att	in by 1	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Plac	ce of Injury - At hom ding, etc. (Specify)	ie, farm, str	eet, factory, office		City or To	wn, State,	d Number or Rura)	u Houte Nur	n <i>ber</i> ,
Division To the Hospitel or Attending within 24 hours after death	To the Funeral Director: Atter completely tilled in by the funera		29a. Certifier X Certifyin	g Physicien: To t	he best of my knowl	ledge, death	n occurred at the time	e, date and place.	and due to the	cause(s)	and manner as s	tated.	
9 Hos	e Fun letely	Medical	(Check only 2 Medical I one)	examiner: On the	basis of examination	n and/or in	estigation, in my opi	inion, death occur	red at the time,	date and	place, and due to	the cause(s)
To th withir	ro th	ž	29b. Signature and title of certifier	00			29c. License	number		29d. Dat	e signed (Month,	Day, Year)	
30) Cin	nice	<u></u>		MD 32	2864		SEPT	EMBER 12	, 200.	5
			30. Name and address of person					C	707 11	- الماس	otan D	0 0	0027
	Sta	te.	Bruce Kress 31. Date filed (Month, Day, Year)	зет, M. I	Registrar's Signatu	o Stre	et, N. W.	, Suite	/U/, Wa	ısn1n	igton, D.	. 0. 2	003/
F	Sta Regist		SEP 15	2005	Registrar's Signatu	Spe							

		4	State of Maryland / Departi	ment of Health and Mental	Hygiene Reg. No. 0	05 31844
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	of Death	3. Time of Death
	Physicia /Medic	_	DONALD IVAN LEDFORD	Month 527	f 12 20	2:30 AM
	Examin		4a. Fecility Name (If not institution, give street and number) 4b	b. City, Town, or Location of Death	4c. County	of Death
				Silver Spring f Under 1 Year If Under 24 Hrs. 8. Date of	Montgo	omery 9. Birthplace (State or Foreign
	Funeral Director		15 M 2 F	Months Days Hours Min. (Month	h, Day, Year)	Country) Erwin TN
<u>.</u>			Usual Residence of Decedent	0	19.10	
	arylan show	_	10a. State 10b. County 10c. City, Town or Locati MD Montgomery Silver Spi			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director		10f. Zip Code	10g. Citizen of V	
	with t					
	ns 23	Funeral	9813 Braddock Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	20903 s Decedent of Hispanic Origin? (Specify Yes of	or No- 14. Rac	States of Americ
9	after or Itan	F.	1 Never Married 2 Married 1 Yes 2 No 1061-	es, specify Cuban, Mexican, Puèrto Rican, etc] Yes 2 ∑] No <i>Specify:</i>		ck, White, etc. v: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, the Medical Evanther I mat be I cilified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1963			
15-	n 72 h "natu	Completed	(Specify only highest grade completed) (Give kin	nt's Usual Occupation and of work done during most of working ONOT use retired)	166. Kind of Bi	usiness/Industry
12	iene.	шо	Elementary/Secondary (0-12) College (1-4or 5+)	er/Cabinet Maker	Crafts/1	Federal Govt.
פַ	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M.		
/lar	Menta Menta arkad atic a	70 E	Amos Ledford		cnown	
Maryland	2 shour and raum		,	Address (Street and Number or Rural Route N		parenter early
e,	1 and Healtl am 27		20a Method of Disposition 20b. Place of Disposition	Braddock Road Silver		City or Town, State
nor	and and and and and and and and and and		1 Surial 2 Cremation 3 Removal from State	tory`or other place) s Cheltenham 09-21-05	Chalta	nham, MD
Baltimore,	perm I. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depa timent of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat; or items 23a or 28a-f show may right yo popular traumatic avent; the Medical Examples interest be notified at once.			Name and Address of Facility Hines-Ri		
Ä	P P P P P P P P P P P P P P P P P P P			00 New Hampshire Ave		ring MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or beart failure. List only one cause on each line.	the mode of dying, such as cardiac or respirat	tory arrest,	Approximate Interval Between Onset and Death
ė i	Physician		Immediate Cause (Final disease or condition a	cular fibrilla	tion	4 hrs.
В	/Medical Examiner		Due to (or as a consequence of):			2 11-
		e e	Sequentially list conditions, if any leading to immediate. Due to (or as a consequence of):			1
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ery Disease		10 years.
o,	e exection and an arrial-tr		resulting in death) Last Due to (or as a conseq ence of):			(
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	d			
9 X	eath certific attending p I for use as I	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Da	ite of delivery
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 Vee 2 No Ve	ctopic pregnancy Other (specify)		onth Day Year
P.O.	y th	hysi	9 Unknown			
	res that igned by be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I. 23e.	. /	tribute to the cause of death?
ord	law requires as been sign 2 should be	ted	Appertension			3 ☐ Probably 4 ☐Unknown
Sec	e law has b ye 2 st	Completed	diper lipidenia		autopsy performed?	Were autopsy findings available prior to completion of cause of death?
of Vital Records,	ate pag		Of Weather the medical	1☐ ¹	Yes 2 2 No	1 ☐ Yes 2 ☐ No
Σ	Phyaician: rthis certificaral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Home 5 ≥		ner (Specify)
Jo (h-	27. Manner of Death 28a. Date of Injury 28b. Time of		crib how injury occur	
Sior	Attanding for death. actor: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No		
Division	for Attancater deatl	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		ition (Street and Numb or Town, State)	ber or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death o	occurred at the time, date and place, and due t	to the cause(s) and ma	anner as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	(Check only one) Medical Examiner: On the basis of examination and/or investigated.	stigation, in my opinion, death occurred at the	time, date and place,	and due to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier	29c. License number	,	ed (Month, Day, Year)
)	5		1 BH Dangs non MJ	D10298	9/13	3/05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri		0010	
		ate	R.H. Sandstrom, M.D. 7701 Carroll Aver	nue Takoma PArk MD 20	1917	
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 15 2005 32 Registrar's Signature	AGL)		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10, 2005 5:00 Jack Lee September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring
Under 1 Year | # Under 24 Hrs. Holy Cross Hospital
Social Security Number 6. Sex Montgomery 5. Social 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**√** M 2□ F 240-12-1229 87 May 1, Director 1918 North Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Tyes 2 XNo Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20903 IISA 8408 Tahona Drive death v Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 271s marked other then 'naturel', or Item any injury or other treumatic event, the Medical Expense. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 1 Painter Residential/Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Parker Walter Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance M. Lee/ Wife 8404 Tahona Drive, Silver Spring, MD 20903 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Sept. 19, George Washington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 2005 21. Signatura I Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, of complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Examiner equires that the death certificate be executed burial-transit Pleural Effusion that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical Renal Failure as the b IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 III Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 has 2 No 1 Yes 2 🔽 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2x No 1x Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Alatural s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a pellil 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 6 3343 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Irina Y. Ruban, M.D. 31. Date filed (Month, Day, T 5 32 Registrar's Signature State DOLLER ! Registrar

			1 - State of Maryl	and / Depa <i>Cer</i>	irtment of F tificate of	lealth and Me <i>Death</i>		giene 005	31846
			Decedent's Name (First, Middle, Last)			2	2. Date of Dea	ith	3. Time of Death
	Physici /Medic		Donald F. McBride			S	Month eptemb	er 13, 2005	7:30 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	h
			Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Laure1	If Under 24 Hrs. 8	Date of Birth	Prince Ge	
Н	Funeral Director		191–28–0398	70 Yrs.	Months Days	Hours Min.	3. Date of Birth (Month, Day)		hplace (State or Foreign untry) nsylvania
	מ		Usual Residence of Decedent				03/23/	1933 1 611	пзутуанта
	show	7		City, Town or Lo	cation				10d. Inside City Limits
	the M	Director	MD Prince George's I	Laurel	10f. Zip Code			10a Citizan of Minat Ca	1 X Yes 2 ☐ No
	a or	iDir	7700 Cherry Lane		20707	•	'	10g. Citizen of What Co	unity?
	filed within 72 hours after death with the Maryland thygiene. ther than "natural", or Itams 23a or 28a-f show int. It e Modical Examiner must be motified at	Funeral	11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Speci	ify Yes or No-	14. Race - Ame	
ထ္	after or Ita		1 X Never Married 2 Married 1 X Yes 2 No If Yes, Give	052_	Yes, specify Cuba ☐ Yes 2 The No	an, Mexican, Puerto Ri Specify:	ican, etc.)	Black, White	e, etc.
8	ural',	d by	3 Wildowed 4 Divorced Year or Dates:	1961					nite
7	in 72 "nat	Completed	15. Decedent's Education (Specify onty highest grade completed)	(Give	ent's Usual Occup kind of work done OO NOT use retired	durina most of working	7	Federal Business/	
72	y with	ome	Elementary/Secondary (0·12) College (1-4or 5+)			pervisor	,	Investiga	
Maryland 21215-0036	e filec al Hyg I othe vant.	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, i		
<u>Xa</u>	Menta Menta Arked	To	Frank McBride			Janet Har			
Mar	2 sho and Is m		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State, Z	
e,	1 and Health em 27 thar t		John K. McBride, Brother 20a. Method of Disposition	16203 b. Place of Dispos		nor Lane, I		Maryland 2	
nor	ages int of l		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	natory`or other plac	ce)		20c. Location - City or	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumatic event. It is Modical Examinational be multilled at once.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			tery 09/17		Brentwood, oln Funeral	
<u> </u>	8258		My Muller					ntwood, MD	20707
Π,			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	or the mode of dyin	ng, such as cardiac or i	respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical	l li	resulting in death)		Obstruc	tive Pulmo	nary D	isease	
П	Examiner		Due to (or as a cor		1 W	.44-1 TE		1	
		Jer	n any, leading to immediate Due to for as a con		II Myocal	dial Infar	CL		
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						
90,	oe exe cian a uriat-l	I Ex	resulting in death) Last Due to (or as a cor	sequence of):					
68760,	ficate be executed physician and is the burial-transit	edical	d						
	E 70.6	/Me	IF FEMALE: 23c. If yes, outcome of pro	egnancy				23d. Date of deli	word.
Вох	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 Ves 2 No. 1 Ves 2 No.	Fetal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
P.O.	t the by the tache	hys	9 □ Unknown 9□ Unknown						
	es tha igned be de	by	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause giv	en in Part I.		bacco use contribute to	
ord	w require been si should I	ted	Renal Insufficiency				1 X . Ye	es 2□No 3□Pro	obably 4 Unknown
ec	e faw i has b	Completed					24a. Was a autops	sy prior to c	topsy findings available ompletion of cause of
a E							perform		2 🗆 No
<u>=====================================</u>	siclar certif rector	o Be	25. Was case referred to medical examiner?		Oth	26. Place of Death			
o	Phys ar this aral d	\vdash	27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA 28c. Injun Wor	4 ☐ Nursing Home y at 28		ence 6 Other (Spec	ify)
<u>o</u>	Attanding Physiclan: r death. ector: After this certifics by the funeral director. I	atioi	1 XNaturał 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	r) Injury		k? Yes 2 ∐No			
Division of Vital Records,	r Atta er dez recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (Sp.		et, factory, office	28	f. Location (St. City or Town	treet and Number or Ru	ral Route Number,
ō	ital or A								
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 (X Certifying Physician: To the best of my (Check only one) 2 Medical Examiner: On the basis of exame and manner stated.	knowledge, death πination and/or inv	occurred at the tine estigation, in my o	ne, date and place, and pinion, death occurred	d due to the call at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier		29c. Licens	e number	2:	9d. Date signed (Month	. Day, Year)
		,	I Jun		Do	13687	S	September 1	4, 2005
	(10)11		30. Name and address of person who completed cause of death						
		7	Joselito D. Magday, MD, 11701 31. Date filed (Month, Day, Year) 37 Registrar's S	Roby Ave	e. Beltsv	ille, Mary	land 2	0705	
	Sta Registr		SEP 1, 6 2005	A Los	de la				

			State State State Registrar State State State Per State Stat	of Maryland / FH G850 12	Depar /05/ /	tment of I	Health a Death			5 31847
	Physici		Decedent's Name (First, Middle, Last) Mark	atthews				2. Date of De Month Septem	Day ber 6, 2	3. Time of Death 9:07 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and Holy Cross Hospital	number)		4b. City, Town, o	or Location of	Death	4c. County	
	Funeral Director		5. Social Security Number 6. Sex 11X M 2	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bit	th Year) 7,1894	9. Birthplace (State or Foreign Country) Alabama
	with the Maryland a or 28a-f show Le noillied at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County District of Columbia 10e. Street and Number 6300 - 8th Street, N.	10c. City, To		ington 10f. Zip Code	11		10g. Citizen of W	10d. Inside City Limits 1 XYes 2 □ No /hat Country? States
215-0036	ges 1 and 2 should be filed within 72 hours eiter death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f show or other treumatic event, the Mudical Erai, it at must be notified at	Completed by Funera	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade complet	Decedent Ever in U.S. Forces? Forces? Signature Signatur	1 [6a. Decede	as Decedent of	Hispanic Originan, Mexican, Specify: pation during most	in? (Specify Yes or No Puerto Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc. Black
2	12 should be filed within " h and Mental Hygiene. 7 is marked other than " treumatic event, the Med		Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	e (1-4or 5+)	Mili	tary En		's Name (First, Middle	J	States Army
Maryland	uld be fi Mental P arked of	To Be	William Matthews				Rei	nner		(unknown)
Mary	d 2 sho th and h		19a. Informant's Name/Belationship (Type, Print) LOUISE Mary Elizabeth Matthew	(Daughter)	9b. Mailing	Address (Stree	t and Number	or Rural Route Numb	er, City or Town,	State, Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If Item 27 I eny Injury or other tre once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify) 21. Snature Funeral Servi & Finese	om State 20b. Place	of Disposit etery, crema ngton	tion (Name of atory or other pla Nation Name and Addr N. Hor	al Cemess of Facility	ept.19,200 etery	Arlingt	City or Town, State
8760,	ate be executed // Medical Examiner and its burial-transit the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	at caused the death. Done ach line. neumonia to (or as a consequence to (or as a consequence to (or as a consequence	ce of):	the mode of dy	ing, such as o	eardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
O. Box 6	the death certific y the attending p iched for use as	Physician/Med	in the past 12 months?	outcome of pregnancy ve birth 2 Petal dea regnant at time of death nknown	ath 3□E	Ectopic pregnanc Other <i>(specify)</i>	гу		23d. Date Mor	e of delivery hth Day Year
٥	n requires that been signed b should be deta	by	Part II. Other significant conditions contributing Coronary Heart Dise		ig in the und	derlying cause gi	ven in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
Vital Records,	The law a ate has by page 2 sh	Completed						24a. Was auto perfo 1 \(\text{Yes}	psy prmed? d	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
Vita	Physiclen: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\text{X} \) No Hospital:	☐ Inpatient 2 X ER/	/Outpatient	3 7 DOA Ot		of Death (Check only sing Home 5 ☐ Resi		or (Spaciful
Division of	or Attending Ifter death. Director: After in by the fune	Certification: T	27. Manner of Death 1 XNatural 5 Pending (1) 2 Accident investigation 3 Suicide 6 Could not be 28e. P		b. Time of Injury	28c. Inju Wo M 1	iry at ork?]Yes 2 □ N	28d. Describe	how injury occurre	
_	Hospite 14 hours Funeral tely filled	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the control on the con							
2	To the within 2 To the comple	Me	29b. Signature and file of certifier 30. Name and address of person who completed			D5	se number 52261		Septembe	(Month, Day, Year)
	9/		Alan R. Segal, M.D.;	1517 Hugo P. Registrar's Signature		le; Silv	er Spi	ing, Maryl	and 209	006
	Regist	ate rar		du &		e e				

The state of the s				For State Registrar	State of Marylar		artment of H		F	Reg. No	005	31848
An Other Themson Street St		Discosio)		1. Decedent's Name (First, Middle, La	st)		-		Month	Day	Year	
## PURPLEMENT OF ADDRESS OF STREET App nor supervised Street	*						1					
Source S		Examin	er						ith			
The property of the property o	34					last birthday)	If Under 1 Year	If Under 24 Hr		h	9. Birthr	place (State or Foreign
Description Description							Months Days	Hours Mir	Apr. 2	19	18 Nort	h Carolina
The part of the pa	Section Section	D			10- 0	. T						10d Inside City Limits
The part of the pa		arylar show	-									
The part of the pa		the M	ecto		rai	in coas				10g, Citize	en of What Cou	ntry?
The part of the pa		with a or	Dir		rt							
The part of the pa		death	era		12. Was Decedent Ever in U	J.S. 13.		Hispanic Origin? (Specify Yes or No-		4. Race - Ameri	can Indian,
The part of the pa	9	or its	F.		1 ☐ Yes 2X No				into i noan, etc.,			etc.
The part of the pa	8	urel',	d b)		Year or Dates:				1	A	frican	
The part of the pa	7	n 72 t	iete	(Specify only highest gr	ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w d)	orking	Ibb. Kind	g of Business/ir	idustry
Libraria 2 Exemators 9/19/2005 Beltsville, Maryland	12	within than than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 4			,		Gov	ernment	
Libraria 2 Exemators 9/19/2005 Beltsville, Maryland	Ď	Hyg Hyg other		17. Father's Name (First, Middle, Last	')			18. Mother's N	ame (First, Middle,	Maiden S	iumame)	
Libraria 2 Exemators 9/19/2005 Beltsville, Maryland	<u> a</u>	uld be Menta Menta rrked rrked	To B	James M. McLeod				Susan	McEachin			
Libraria 2 Exemators 9/19/2005 Beltsville, Maryland	lan	2 sho and h is ma	·	19a. Informant's Name/Relationship	(Type, Print)							
Libraria 2 Exemators 9/19/2005 Beltsville, Maryland		and lealth m 27				_			-			
23. Part : Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once leach the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once leach the death. Do not enter the mode of dying. Approximate shock, or heaf it aliure. List only once leach the same place and shock or heaf it aliure. List only once leach the same place and shock or heaf it aliure. List only once leach the same place and shock or heaf it aliure. List only once leach the same place an	0	The state of the s		1 ☐ Burial 2 🛣 Cremation 3 🛭	Hemoval from State	cemetery, cre	matory or other pla	ce)				
23. Part : Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once class or leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once leach the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once leach the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heaf it aliure. List only once leach the death. Do not enter the mode of dying. Approximate shock, or heaf it aliure. List only once leach the same place and shock or heaf it aliure. List only once leach the same place and shock or heaf it aliure. List only once leach the same place and shock or heaf it aliure. List only once leach the same place an	量	nimer Pa						and the last of th				
Pity sician Medical Examiner 2	Ba	Depa Impo any i		Incha's	Thou sou	100						3454000000
Pilysicial (Medical Examiner) Sequentially ist conditions, southing in death) Sequentially ist conditions, and in the past 12 months? I go the type as a consequence of): Cardiomyopathy C	4	**		23a. Part1. Enter the disease, or con	pplications that caused the dea						0,0011,	Approximate
Companies Comp	100	Physician		Immediate Cause (Final		o hear	t failur	2				Onset and Death
Sequentially list conditions: Sequentially list conditions are proportionally list conditions are proportionally list conditions.		/Medical		resulting in death)			rarrar,	-				
The part of the pa		Examiner		Sequentially list conditions.	b. <u>Cardiomy</u>	pathy						
Process Proc		pe sit	iner	d any, leading to immediate cause. Enter Underlying								;
Process Proc	_	xecute and II-tran	xan	that initiated events	0.		rction					
FEMALE: 23b. Was decoded pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	,09	sician buria	alE									
So that a special contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of death? Part III. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant	687	ificate g phy: as the	ed		_ u.							
So that a special contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of death? Part III. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant conditions contribute to the cause of death? Part II. Other significant	ŏ	endin use	M/us	23b. Was decedent pregnant			∃Ectopic pregnanc	v		23		
The state of the s		0 0 0	sicis	1 ☐ Yes 2 ☐ No	4 Pregnant at time of			<u></u>			MOITH	Day 16a
25. Was case referred to medical examiner? 1	P.	d by testach	Phy		contributing to death but not re	culting in the I	inderlying cause di	ven in Part I	23e. Did to	obacco us	e contribute to	the cause of death?
25. Was case referred to medical examiner? 1		signe t be d		Part II. Other significant conditions	contributing to death but not re	Sulling in the t	indenying cause gr	voit in t art i.				
25. Was case referred to medical examiner? 1	Ö	requ been shouk	etec		-				24a Was	20	24h Were aut	onsy findings available
25. Was case referred to medical examiner? 1	Rec	has ge 2	mp						autor perfo	rmed?	prior to co death?	empletion of cause of
The state of the s	a		O	25. Was case referred to medical				26. Place of D			I LI TES	2 NO
The standard of the standard o	<u>></u>	ysicis is cert direct		examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA				X Other (Speci	y) son's home
A Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 29b. Signature and fittle of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Name and a dress of person who completed cause of dean (Item 23a) (Typ). Print) Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895			L:uc		28a. Date of Injury (Month, Day Year)		of 28c. Inju	ry at	28d. Describe f	now injury	occurred	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Typ). Print) Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895	Si		catic	2 ☐ Accident investigation	on he]Yes 2 □No				
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Typ). Print) Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895	ĬŞ	or Att	rtifi	dotormino	289. Place of injury - At i		reet, factory, office				Number or Hur	al Houte Number,
30. Name and a dress of person who completed cause of death (Item 23a) (Typ). Print) Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895		pitel ours a eral [29a Certifier 1 Gertifying P	hysician: To the hest of my kr	nowledge dea	th occurred at the t	ime, date and pla	ce, and due to the	cause(s) a	and manner as	stated.
30. Name and a dress of person who completed cause of death (Item 23a) (Typ). Print) Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895		24 hc 24 hc Fun etely	dica	(Check only 2 Medical Exa		ation and/or in	nvestigation, in my	opinion, death oc	curred at the time,	date and	place, and due t	to the cause(s)
30. Name and a dress of person who completed cause of death (Item 23a) (Typ). Print) Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895		To the within To the	Me	29b. Signature and title of certifier		0	29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
Lynne Diggs, M.D. 10400 Connecticut Ave. #206, Kennsington, MD 20895)			Typu	26	X	D344	472		Sept	ember 1	4, 2005
)		30. Name and a dress of person who	completed cause of deam (Ite	m 23a) (Typ	, Print)					
State 31. Date filed (Montin, Day, Year) SEP 16 2005								06, Kenn	sington,	MD .	20895	
					005 Hegistrar's Sign	A A	sets.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) sept. **Physician** MANLEY 12:06 PM KENNETH ٤. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 6. Sex 1**⊠** M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/18/1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 62 North Carolina 237-80-8724 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. sther than "naturaf", or tlems 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County itam 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examt, an must be excitive at 1 Yes XXNo Director Md. Howard Columbia 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 10169 Goodin Circle 21046 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1XYes 2□No 1966— If Yes, Give Year or Dates: 1968 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4yrs Elementary/Secondary (0-12) Real Estate General Manager and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked othany or other traumatic event Be Robert Manley Gladys Jones ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10169 Goodin Circle Columbia, Md. 21046 Peggy P. Manley/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Columbia Memorial 9/23/2005 Columbia, Md. ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F. H. Inc. 21. Signature of Funeral Seprit MOO845 4112 Old Columbia Fike Ellicott City, Nd. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mestasta 8 months alon Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes S No 2 🗆 No 1□ Yes 1 TYes or Attanding Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 3 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 2 No 1 Tyes 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number D23601 02 Patuxent Phwy, Columbia, MAZ1044 death (Item 23a) (Type, Print) EE, 11065 ittle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 115 3 1850

				epartment of Health and Mental Certificate of Death	HygiefaeUUJ 31030 Reg. No.
	Physici	an.	Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year
	/Medic		Jerry Lee McCulley	SEPTU	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death EASTO U	4c. County of Death
			M2MDRIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(av) If Under 1 Year If Under 24 Hrs. 8 Date of	f Birth 9 Birthplace (State or Foreign
,	Funeral Director		220–28–1294 ¹ № ™ ² □ F 76 Yrs	Months Days Hours Min. (Month	n Day, Year) 1 21, 1929 Maryland
	ס		Usual Residence of Decedent		10d leade Citylimite
\bigcirc	show	2	10a. State 10b. County 10c. City, Town o	Easton	10d. Inside City Limits 1 Yes 2 □ No
Z	28e-f	ecto	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3	aa or	Funeral Director	700 Port St., Unit 108	21601	USA
1	ms 2;	nera		13. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc	n No- 14. Race - American Indian,
36	s within 72 hours after death with the Maryland itene. r than "neturel", or Items 23a or 28e-f show the Medical Examerar must be notified at	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Specify:	Black, White, etc. Specify: White
21215-0036	2 hour		15 Decedent's Education 16a De	ecedent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 ene. than "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Rive kind of work done during most of working fe. DO NOT use retired)	
	filed wit Hygiene other tha	Con	11 5+	teacher	public school
Ind	d tal	Be	17. Father's Name (First, Middle, Last) James L. McCulley	18. Mother's Name (First, Mi	
Maryland	should be ind Mental s marked o umatic eve	10		lailing Address (Street and Number or Rural Route N	
Ma	2 8 8			8 Woodland Acres, East N	
	os 1 and 2 of Health item 27	1 8	20a Method of Disposition 20b. Place of D	isposition (Name of Date crematory or other place)	20c. Location - City or Town, State
m 0	0 0		1X Burial 2 Cremation 3 Hemoval from State	1's P.E. Cem. 9/19/05	Vienna, MD
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Thomas	Funeral Home P.A.
	40144		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one was on each line.	700 Locust St., Cambrid	
	Pnysician		shock, or heart failure. List only one was on each line. Immediate Cause (Final disease or condition		Interval Between Onset/and Death
	/Medical		resulting in death) a Due to (or as a consequence of)		
h	Examiner	_	Sequentially list conditions, b. Due to (or as a consequence of)		
1	ed .	ine	if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause, Disease of injury		
_	ticate be execute physician and s the burial-trans	Examine	that initiated events c	:	
68760,	sician buris	al	d		
	itticate g phy as the	edical			
Вох	leath certitica attending pt I for use as ti	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy	23d. Date of delivery
	The law requires that the death certiticate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves 2 No 9 Unknown	5 Other (specify)	Month Day Year
P.0	hat th ad by detach		Part Il Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
Vital Records,	signed I	d by	Ture ved cell appared.		1 Yes 2 No 3 Probably 4 Unknown
COL	w require been si should b	lete		24a.	Was an 24b. Were autopsy findings available
Re	he lav e has	Completed			autopsy prior to completion of cause of death?
tal		O	25. Was case referred to medical	1 ☐ Y 26. Place of Death (Check of	
ί	Physicien: this certificated director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.	Other	Residence 6 ☐Other (Specify)
n of			27. Manner Death 28a. Date of Injury 28b. Tim 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju		ribe how injury occurred
sio		catle	2 Accident investigation	M 1 Yes 2 No	
Division	atter d Direct	Certification:	4 Homicide determined 28e. Place of Injury · At home, farm building, etc. (Specify)	, street, factory, office 28f. Locati City o	ion (Street and Number or Rural Route Number, r Town, State)
	To the Hospitel or Attenwithin 24 hours after death To the Funerel Director: completely tilled in by the	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, c (Check only 2 Medicel Exeminer: On the basis of examination and/		
	thin 2 the control of the control	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month Day, Year)
	7 × 5	1	I Cust MAN	7391507	9/16/101
,			30. Name and address of person who completed cause of death (Item 23a) (Ty	/pe, Print)	11 100
			David H. Smith, M.D. 29466 Pint	ail Dr. Suite 5, Easton,	MD 21601
		ate	31. Date filed (Mon Star PY et r) 9 2005 32. An istrar's Signature	South)	
	Regist	rar			

JEKRY MUCHULEY

			1 - For State Registrar	State of Maryla		artment rtificate			nd Mental H	ygien Reg. Ni	/ 111)5	31	851
	Physici /Medic		Decedent's Name (First, Middle, Last, Elizabeth William						2. Date of D Month Sept	eath Da		Year 2005		of Death
	Examir		4a. Facility Name (If not institution, give 55 E. Washingtor	street and number)			Ha	Location of D	Death DWN	7	c. County	of Death ngto	n Coi	inty
	Funeral Director		5. Social Security Number 6. Sec. 223–28–9198 Usual Residence of Decedent	M 22XF	rs. last birthday) 86 Yrs.	If Under Months	Days	If Under 24 Hours	Min. (Month, L	ay, Year	918	Coun	ace (Stat try) ginia	e or Foreign 1
	e-f show	ctor	Maryland Washing		City, Town or Lo Hage	erstow	n					10		City Limits es 2 ☐ No
	h with the 23e or 28	Funeral Director	10e. Street and Number 55 E. Washington	st		10f. Zip	Code 217	40			itizen of W	Vhat Coun	try?	
920	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "netural", or Items 23e or 28e-1 show atte event, the Medical Examinat minal be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decede		spanic Origin n, Mexican, F Specify:	? (Specify Yes or Noverto Rican, etc.)	0-	Blac	e - America k, White, e Whi	etc.	
Maryland 21215-0036	1 within 72 ho liene. r then "netur the Medical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usuai kind of work DO NOT use Homem	k done d e retired,	uring most of	f working			siness/Ind		nce
and	ild be filed lental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) John Douglas Wi	.lliams, Sr.				18. Mother's	Name (First, Middle Lie Hudgi:	e, Maider	Surname	е)	2001	
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23e or 28e-f show any highry or other treumatic event, the Madical Examinating must be notified at ance.		19a. Informant's Name/Relationship (Ty Carol M. Barton (20a. Method of Disposition 1 Disposition 3 Property (Specify)	daughter)		Jarresition (Nam	etts e of her place	ville	Rd. Jarre Date -14-05	ettsv 20c. L	ville		land	
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service License	of Lucy	1	Name and	Addres aste	s of Facility rn Blv	Douglas A	A. Fi jerst	ery own	Funeı Mary	al H	Iome 21742
8760,	death certificate be executed By American and American and for use as the burial-transit	dical Examiner	23a. Part1. Enter the essease, or complished, or head failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		equence of):				rdiac or respiratory				Approxim Interval B Onset an Mir.	letween d Death
.O. Box 68	at the death certifica by the attending ph tached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ F. 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pre					23d. Date Mon	of deliver	y Day	Year
٥.	The law requires that the tee bas been signed by the bage 2 should be detache		Part II. Other significant conditions cor	ntributing to death but not r	esulting in the ur	nderlying ca	use give	n in Part I.		tobacco Yes 🎗		ibute to the		f death?
al Records,		Completed							24a. Was auto perf 1 🗆 Yes		pr de	Vere autop rior to com eath?	pletion of	s available cause of
Division of Vital	Phys this al dii	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 □ Inpatient 2 28a. Date of Injury (Month, Day Year)			c. Injury Work	4 🗆 Nursir	Death (Check only ing Home SCXRes 28d. Describe	idence				
Divis		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, streetly)	eet, factory,	office		28f. Location City or To	Street ar wn, State	nd Numbe e)	or Rural	Route Nu	mber,
	To the Hospitel or within 24 hours after To the Funerel Dii completely filled in	edical	29a. Certifier (Crieck only one) Certifying Physical Examination (Crieck only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred a	t the time	e, date and p nion, death o	lace, and due to the occurred at the time,	cause(s date and) and man d place, ar	ner as sta nd due to t	ted. he cause	(s)
	To the within 2 To the complete	Ñ	29b. Signature and title of certifier	9889	om 22a) /Ti	I	License D283				te signed ·16-0	(Month, D	ay, Year)	
H	/-3 Sta	10	Manzar Shafi 368	Mill Street			1D :	21740						
	Registr	• 2	31. Date filed (Month Pay Year) 20		B. So	ويعده								

		1- State of Maryland / Department of Health and M Certificate of Death	Reg. N	2005 31852
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last) Oliver Phillipps Merchant, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		3. Time of Death 14, 2005 11:18P M c. County of Death
Funera Directo	ľ		8. Date of Birth	Frederick 9. Birthplace (State or Foreign Country) West Virginia
partitioner, interpretation 2.12.13-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Example in withing at		Oliver P. Merchant 19a. Informant's Name/Relationship (Type, Print) Mary M. Wharton/Sister 19b. Mailing Address (Street and Number or Run 19b. Mailing Address (Street and Number or Run 19c. Method of Disposition 1	pecify Yes or No- period Rican, etc.) 16b. Ve. Mai Maide (First, Middle, Maide 11e Maddox ral Route Number, City Ve. Ranson Date 20c. 9/05 She Co., Inc.	or Town, State, Zip Code)
The law requires that the death certificate be executed the law requires that the death certificate be executed the law requires that the death certificate be executed to the attending physician and the law reaction of the law reactions is the purial-transit to the law reactions as the purial-transit to the law reactions are the law reactions.	Examiner	23a. Part Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injurithat initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	or respiratory arrest,	Approximate Interval Batween Onset and Death Mounts
hat the death certific dby the attending plate as as fetached for use as fetached	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
The Collection of the law requires that the de- te has been signed by the a age 2 should be detached the	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pick's cluster, renal in Sufficiency, Droster Cancer		a use contribute to the cause of death? 2
Physician: The lave this certificate has all director, page 2	Be Completed	25. Was case referred to medical 26. Place of Dea	autopsy performed? 1 □ Yes 2 ☑	prior to completion of cause of death? No 1 Yes 2 No
Jing Jing After funer	Certification: To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Sta	jury occurred and Number or Rural Route Number,
LIVISION To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medicai C	29a. Certifier (Check only one) 1 → Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	rred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s) Date signed (Month. Day, Year)
+3F8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		116/05 Md. 21716
Regi	State strar	Kathleen W. Stern MD 610 Ninth and Bra. 31. Date filed (Month, Day, Year) 2005 Registrar's Signature Specific	unsurek,	MU, 41116

DHMH 17 Rev 1/2001

Registrar

15

2005

		•	For State Registrar		State	of Marylar			nt of H te of L		and Me	-	giene	1000	3185	4
	Dharaisi		1. Decedent's Name (Firs	st, Middle, La	st)						2	. Date of De			3. Time of De	ath
	Physicia /Medic		John M	illard	Noe1						S			18, 200	5 8:44 A	7 M
	Examin	er	4a. Facility Name (If not in	_		ımber)				Location o	f Death		40	. County of Dea	th	
			614 Cole			1 To A //-	6 - 4 1 1 dt 1 1		rryvi er 1 Year	11e If Under 2	74 Hec. 1	5		Cec		
	Funeral Director		5. Social Security Number 219–28–1289		sex 15∏ M 2 ☐ F	7. Age (In yrs.	Yrs.	Months		Hours	Min.	Date of Bir (Month, Da	ay, Year,	1	thplace (State or Fo	oreign
			Usual Residence of Dece			74					ЙC	vembe	r24,	1930	Maryland	
	yland		10a. State 10b.	. County		10c. C	ity, Town or Lo	cation							10d. Inside City L	imits.
	e Ma	ctor	Maryland	Ceci	1			P	erryv	ille					11X Yes 2	□No
	ith th or 28	Director	10e. Street and Number						ip Code		200		-	tizen of What C	•	14
	ath w		614 Cole	Stree						219				nited S		
	lteme	Funeral	11. Marital Status	253 Marriad	Armed F		J.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Orig n, Mexican	gin? (Specif , Puerto Ric	y Yes or No can, etc.)	0-	14. Race - Am- Black, Whi		
39	urs aft	by F	1 Never Married 2 3 Widowed 4 1		If Yes, G	2 ☐ No live Dates:	i i	1 ☐ Yes	2 ∑ No	Specify:				Specify:	White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural", or Items 23a or 28e-f show event, the Madical Examiner must be notified at	ted		Decedent's E			16a. Dece	dent's Us	ual Occupa	ation			16b. K	(ind of Business	/Industry	
215	e. an "n	Completed	Elementary/Secondary		ade completed College)(1-4or 5+)	life.	DO NOT	use retired,				Pe	erry Poi	nt Vetera	ans
2	filed wi Hygien other th	Con	12					Nurs	ing A	ssist				dical (enter	
and	2 should be filed within and Mental Hygiene. is markad other than eumatic event, Ite M.	Be	17. Father's Name (First, John Fr									First, Middle				
3	should b ind Ment s markad umatic e	2	19a. Informant's Name/F				10h Maili	- Andalas	/Ct			'irgin			T 0 / 1	
Maryland	カルトサ				,		1	_						or Town, State,		
	permit. Pages 1 and 2 Department of Health Importent: if item 27 i any injury or other tre 2006.		Betty June 20a. Method of Disposition		- wile	20b.	014 _C Place of Dispo cemetery, crei	ote	Stree	τ - P	erryv			yland ocation - City or		
Baltimore,	Pages ent of ht: If i		1 🖾 Burial 2 🗆 Cre `4 □ Donation 5 □ 0				rth Eas	t Me	thodi	.st ¦5	eptem					1
턡	mit. Fartmoorter	i	21. Signature Funeral				Cer	eter . Name	y and Addres	s of Facility				h East, 11 Home	Maryland	1
ä	Deparenti Deparenti Importany ir		Nobble								CTOU				[aryland2]	1901
			23a. Part1. Enter the dis shock, or heart failu	sease, or con	plications that	caused the dea									Approximate Interval Betwee	
	Physician :	i u	Immediate Cause (Final disease or condition		Met		Pau	AN	outic	C	anc	a			Onset and Dear	
	/Medical Examiner		resulting in death)		- u	(or as a conse										
	LAUTHITE	<u>_</u>	Sequentially list condition	ns,	b. Dun to	(or as a conse										
	ted nsit	Examine	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury	ate ⊀	Due to	(Or as a conse	quence or):									
<u>,</u>	sician and burial-transit	Exar	that initiated events resulting in death) Last		cDue to	(or as a conse	quence of):									
8760,	death certificate be executed te attending physician and ad for use as the burial-transit	cai		•	d											
9	tificat ng phy as th	<u> </u>		- 05	30											
Вох	leath certific attending pl	an/Me	IF FEMALE: 23b. Was decedent preg			utcome of pregr birth 2 Pet		Ectopic	pregnancy				1	23d. Date of de		
.O.	the dea y the at iched fo	O	in the past 12 montl 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	IIS?	4∏Preg 9∏Unki	nant at time of	death 5	Other (specify)					Month	Day Year	'
<u>G</u>	= 0 to	Physi	Part II. Other significant	conditions	contributing to	death but not re	sultina in the u	nderlving	cause dive	en in Part I		23e. Did 1	tohacco	use contribute to	the cause of death	h?
ecords,	se un es	d by	100												robably 4 Unkr	
COL	> 9 0	ompleted										24a. Was	20	24h Were a	utopsy findings avai	ilable
$\mathbf{\Xi}$	9 - 9	duic										auto perfo	psy ormed?	prior to death?	completion of cause	e of
Vital	lcien: Th certificate ector, pag	e C	25. Was case referred to	medical						26 Place	of Death (1 Yes	2.€No	1 □ Yes	22 No.	
Ţ	is dir	To B	examiner?		Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 🗆 E	Othe	20				6 ☐Other (Spe	cify)	
n of			27. Manner of Death	Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o	f	28c. Injury Work	at	280	d. Describe	how inju	ry occurred		
sio	Attending r death. ector: After by the fune	cath	2 Accident	investigation				М		res 2□N	No					
Division	of or Attendate death I Director:	Certification:	4 Homicide	determined	200. Flat	e of Injury - At hading, etc. (Spec	nome, farm, str ify)	eet, facto	ry, office		281	Location (City or To			ural Route Number,	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1	Certifying P	hvsician: To th	e best of my kn	owledge death	h occurre	d at the tim	e date acc	1 place sec	1 due to the	causo/s) and manner a	stated	
	Hose Hose Pur Peterly	edical	(Check only 2 1	Medical Exa	miner: On the	basis of examin	ation and/or in	vestigatio	n, in my op	pinion, deat	h occurred	at the time,	date an	d place, and du	to the cause(s)	
	To the within 2. To the I complet	Me	29b. Signature and tite	of ceptiling	1	1.17		2	9c. License	number			29d. Da	ite signed (Mon	h, Day, Year)	
			•	1//	1/10	Hund			D35	5653	3		91	20/05	-	
	12+1VA		30. Name and address of	i person who	completed car	se of death (Ite	m 23a) (Type,	Print)		- L -	i /	.1 0	11. 1	104.0	21921	
			Martha	Host	was 1	A L) Registrar's Sign	11 W	. #	gh ?	ST, St	2/0	4 6	Kto	n, IND	X1121	
	Sta Registr		31. Date filed (Month, Da	P 2 0		Registrars Sign	B A	red								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Reg. No. 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PAUL RUDOLPH NIMMERRICHTER SEPTEMBER 1:04 PM M 14, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LA PLATA, MARYLAND
If Under 1 Year If Under 24 Hrs. 8. Date
Months Days Hours Min. Mo CHARLES 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington DC 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 X M 2 □ F 75 Director 217-28-1600 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiens. The and Mental Hygiens, "7] Is marked other then "natural", or itams 23s or 28s-f ehov treumsite event, Ita Modical Examination and Lea Modical as Nimmerrichte 1 ☐ Yes 2 X No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 USA 14700 Woodville Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis A. Nimmerrichter Angelina Epp ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Robert Nimmerrichter-Son 3600 Mount Pleasant Road, Waldorf, MD 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 DeBurial 2 Cremation 3 Removal from State permit. Page Department of Important: if eny injury or once. Trinity Memorial Gdns 9-20-2005 Waldorf, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility M01391 P. O. box 156 Huntt Funeral Home Waldorf, MD 20604 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myscardia /Medical Dog to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign t be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has l page 2 s autopsy perform 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature appt title of certifier 3005 DH-0058095 s of person who ompleted cause of death (Item 23a) (Type, Print) HARDY, CONYA L., MD 11345 PEMBROOKE SQUARE SUITE 104 WALDORF, MARYLAND 20603 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State SEP 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiehoe0.051 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 15, **Physician** September John Perdoe Neigh 2005 11:45 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 87 Yrs. 003-03-2104 1918 New Jersey Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic evant, the Madical Exeminer must be notified at 1 K Yes 2 □ No Maryland Harford Havre de Grace Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 112 Baylands Drive 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Itams 11. Marital Status 1 ⊠Yes 2 □ No Il Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. nt: If itam 27 is markad other than "natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
V.A. Medical Center Elementary/Secondary (0-12) Coltege (1-4or 5+) Perry Point, Maryland Twelve Years Supervisor Dietetic Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William S. Neigh Violet Rae Perdoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If itam 27 is any injury or othar trat once. Virginia R. Neigh (wife) 112 Baylands Drive, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place St. Andrew's Catholic Church Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 09/19/05 Waynesboro, Pennsylvania 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each linen Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, any, reading to increallate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and resulting in death) Last Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfo 1 ☐ Yes 2 ☐ No 1 Yes Vita 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tes of 27 May er of Death 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attanding 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Ite FIVIT 31. Date filed (Month, Day, Year) 32. Rehistrar's Signature State SEP 1 6 2005

Registrar

CT05-06186 O'Donnell, Terrance

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O F

		For
1	-	State
		Registrar

Certificate of Death

-	~	U	1 E	7	4	ı
	Reg.			U	J	

Physician	
/Medical	
Examiner	

TERRENCE M. O'DONNELL

1. Decedent's Name (First, Middle, Last)

2. Date of Death Month Year September 2005 3. Time of Death 6:40 PM^M

857

Fun

Direc

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Implant of Heelth and Mental Hygiene. Implant if Item 27 is marked other than "maturel", or Iteme 23e or 28e-1 ehow

Baltimore, Maryland 21215-0036

Physic /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the attending physicien and After this certificate hes been signed by the attending physicien and Division of Vital Records, P.O. Box 68760,

. Fecility Name (/	r not institution,	give street and num	iber)		4b. City, I	own, or Locatio	n of Death	1	4c. C	ounty of Dea	ith	
311 Fall Lane Easton								Talbot				
								8. Date of Bi (Month, D	inth ay, Year)	C	rthplace (State or Foreign	
				Trs.				SEPT.	26, 19	38	ILLINOIS	
	T		10c. Ci	ty. Town or Lo	ation						10d. Inside City Limits	
MD		OT									11∑Yes 2 □No	
e. Street and Nu	10f. Zip (Code			10g. Citize	n of What C	ountry?					
311 FAL	2	1601				USA						
. Marital Status		12. Was Dece	dent Ever in U		/as Decede	ent of Hispanic (Origin? (S)	pecify Yes or N	0- 14			
_		d 1 📉 Yes If Yes, Give	2 □ No e					S	Specify: WHITE			
(Spec		(Give	and of work	k done durina m	ost of wor	king	16b. Kind of Business/Industry					
	ondary (0-12)		4or 5+}			e retired)			TT C	T. C. COMPINITION		
	(First Middle L			AMA	LISI	18 Moi	ther's Nam	an /First Middle			RNMENT	
									s, maider St	omame)		
				19b. Mailin	g Address (per, City or 1	own, State.	Zip Code)	
EDITH O	'DONNEL	L/WIFE										
a. Method of Dis	position	· —		Place of Dispos	ition (Name	e of		Date		ition - City or	Town, State	
			state		,	,	CTR 9	9/12/200	5 STE	VENSV	ILLE, MD	
Joseph	m. 6	Strouski	C.F.S	R 2	PPTR.	BARRIS	6NR 21	r ⁿ eàsibh	ANAMD E	71661	L HOME PA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Year			
rt II. Other signif	icant condition	s contributing to de	ath but not res	sulting in the un	derlying car	use given in Par	rt I.	23e. Did	tobacco use	contribute to	o the cause of death?	
DIABE	ES 17	ELLITUS	; CHR	ONIC	EMA	TUELISI	M_	10	Yes 2□I	No 3∏P	robably 4 🗷 nknown	
								auto	ormed?	24b. Were as prior to death?	utopsy findings available completion of cause of	
25. Was case referred to medical 26. Place of Death Check only one								_	1)ZSVY es	2 □ No		
examiner?									XOther (Spe	scitu) Scene		
		28b. Time of Injury		c. Injury at Work?								
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	280. Place	of Injury - At h	ome, farm, stre	et, factory,	office		28f. Location (City or To	Street and f wn, State)	Number or R	ural Route Number,	
(Check only one)	1 Certifying 2 Medical E	xaminer: On the ba	sis of examina	wledge, death ation and/or inv	occumud al estigation, i	t the time, date in my opinion, de	and place, eath occur	and dua to the red at the time,	cause(s) an date and pl	d manner as ace, and due	stated,	
				_							7 (0 (1)6 (4036(3)	
b. Signature and	title of certifier	` `			29c.	License numbe	r		29d. Date s	signed (Mont	h, Day, Year)	
	Social Security N 319-30-0 Ital Residence of a. State MD B. Street and Nur 311 FAL Marital Status 1 Never Marr 3 Widowed (Spec Elementary/Secc 12 Father's Name OSEPH O Da. Informant's N. EDITH O Da. Method of Dist 1 Burial 2 4 Donation Signature of Full Signature of Full Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 2 1 Signature of Full Burial 3 2 Signature of Full Burial 3 3 Sign	Social Security Number 319-30-0039 Ival Residence of Decedent a. State 10b. County MD TALB Ival Status State 10b. County MD TALB Ival Status Marital Status Marital Status Midowed 4 Divorced Specify only highest Sementary/Secondary (0-12) Father's Name (First, Middle, L. Ival Informant's Name/Relationshi Ival Informan	Social Security Number Social Security Number	Social Security Number \$19-30-0039 March Security Number Security S	Social Security Number Social Security Num	Social Security Number 6. Sex 12 Medical Security Number 10 Medica	Scala Security Number 6. Sex 7. Age (in yrs. last birthday) Funder Year Hunder Year	Social Security Number G. Sex 100 M 2 F 7. Age (in yrs. last birthday) H Under 1 Year If Under 2 Hers. Months Days Hours Min.	Social Security Number G. Sex T. Age (in yrs. last brithday) Hurder Year Hunder 24 Hrs. S. Opar of 8 S. Opar of 18 S. Opar o	Social Security Number Social Security Num	Talbot Female Social Security Number Social Security	

State Registrar

111 Penn Street Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO

31. Date filed (Month, Day, Year) 2005

, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 State of Maryland / Department of Health Andrew / Department / D 31858 2. Date of Death Month SEPT 12 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Florence Hester Petajnik 2005 4:04 P

Funeral Director permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, Ira Medical Exercise man be notified at once.

FLORENCE PETAJNIK

Physician

Examine

Physician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

cal				41 03 =		SEPI I		4:04 P			
ner	4a. Facility Name (If not institution, given CIVISTA MEDICA				r Location of Death APLATA		4c. County of E				
		Sex 7. Age (In yrs. I	last hirthday)	If Under 1 Year	AFLATA If Under 24 Hrs.	8. Date of Birth					
		1MM 2□F 82	Yrs.	Months Days	Hours Min.	Month, Day, April	Year)	Birthplace (State or Foreign Country) West Virgin			
	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits			
to	MAryland Char	cles Br	yans	Road			1 □ Yes 2 □				
lrec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?			
D	3432 Peerless	Place		2061	6		U.S.A.				
Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	1 ☐ Yes 24 ☐ No			ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.			
ted by	3 Novidowed 4 □ Divorced 15. Decedent's E	Year or Dates:	16a. Deced	1 ☐ Yes 2 X No dent's Usual Occup	Specify:			White Kind of Business/Industry			
Completed	(Specify only highest gri	ade completed) College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retired	during most of work d)		,				
EOC	9	0011090 (1 407 017	Cafet	eria V	Vorker	I	Board of	Education			
Be	17. Father's Name (First, Middle, Last	1)			18. Mother's Name	e (First, Middle, M	Maiden Sumame)				
To E	Daniel VanMetr	ce			Flore	nce C.					
•	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street	and Number or Run		City or Town, Stat	e, Zip Code)			
	Albert W. Peta	ajnik Son	3432	Peerle	ess Plac	e, Brya	ans Road	d, Md. 20616			
	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	econt 2	Date 2005	20c. Location - City	or Town, State			
	1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 State 200, 2005 Check of Disposition (Name of Disposition) Maryland Veterans Cemetery Cheltenham, Maryland Veterans Cemetery										
	21. Signature of Funeral Service Lice	M006	68	Villiams 270 Hav	s Funera thorne	l Home Rd., I	P.A. ndian He	20640 ead, Md.			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between										
	Immediate Cause (Final disease or condition	ADYONOCA				· CNO		Onset and Death			
	resulting in death)	Due to (or as a consequ		0 011014	1		1	177.600100			
		· Thecom	Fren	1CTVCP	1000 A	The work	E COM	The LUNG			
e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):								
Ē	Cause (Disease or injury that initiated events	C			0	11/2					
Examlner	resulting in death) Last	Due to (or as a consequ	uence of):			17 m	OVED BY MEDICAL EXAMINER				
cal	(d				W APPROVED BY	MEDICAL				
ed					CERTIFICATION						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	23c. If yes, outcome of pregna. 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month				
-	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?			
d b	Pelvic fracture			, , ,			• /	Probably 4 Unknown			
etec						-	`				
Completed	24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☑ No										
Be (25. Was case referred to medical examiner?			26. Place of Death (Check only one)							
٥	1∰ Yes 2∭ No	Hospital: 1 ☐ Inpatient 2 🗵	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☑ Accident investigatio	(Month, Day Year)	28b. Time of Injury Unknow	28c. Injun Wor 1 1	k')		escribe how injury occurred oject fell				
Certification:	3 Suicide 6 Could not be determined		me, farm, str	eet, factory, office		28f. Location (Str. City or Town 3432 Pe	eet and Number of State) Brya erless P	Rural Route Number ns Road, MD Lace,			
edical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the ting restigation, in my o	ne, date and place.	and due to the ca	use(s) and manner	as stated.			
Me	29b. Signature and title of certifier	AND L	m	29c. Licens D-20		29d. Date signed (Month, Day, Year)					
	30. Name and address of person who	completed cause of death (Item	12a\ /Turs=	Brint)			11.				

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 5 2005

GEORGE H. WATHEN MD 11345 PEMBROOKE SQ. STE 103 WALDORF, MD 20603

32. Registrar's Signature

				1 - For Stata Registrar	State of	Maryland	d / Depa <i>Cer</i>	rtment o	f Healt of Dea	h and N <i>th</i>		giene 0 0	5	31859			
		Physicia		Decedent's Name (First, Mid		A MARYJANE PEAKER					2. Date of De Septem	3. Time of Death					
/Medica Examine				4a. Facility Name (If not institut UPPER CHESAP)			IR.	4b. City, Town, or Location of Death BEL ATR			1	4c. County	4c. County of Death HARFORD				
		Funeral Director		5. Social Security Number 217–50–6120	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. I. 57	ast birthday) Yrs.	If Under 1 Y Months Da	ear If Un ays Hou	der 24 Hrs. Irs Min.	8. Date of Bir (Month, Da June 1	7, 1948	Cour	lace (State or Foreign try) ryland			
		and		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City	r, Town or Loc	ation					1	0d. Inside City Limits			
		Maryl	ţō	Maryland	Harford			Ed	gewoo	d				1 ☐ Yes 2X No			
		or 28e	Director	10e. Street and Number		•		10f. Zip Co				10g. Citizen of W	/hat Cour	itry?			
0		eath w		1003 Crim	son Tree Was Dece	LY ident Ever in U.:	S 13. V	/as Decedent		Official (Sr	pecify Yes or No	- 14. Race		an Indian.			
2000	36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28e-1 show other treumatic event. Its Medical Examinar must be notified at	by Funeral	1 Never Married 2 M 3 Widowed 4 Divorce	rces? 2 (XNo 'e ates:	If Yes, specify Cuban, Mexican, Pu					Blac	Black, White, etc. Specify: Black					
0	5-0036	72 hou	eted	15. Deced	ent's Education hest grade completed)		16a. Deced	ent's Usual O	ccupation one during	most of work	king	16b. Kind of Bu	16b. Kind of Business/Industry				
1.	2121	filed within Hygiene. other than "	Completed		Elementary/Secondary (0-12) College (1-4or 5+)				(Give kind of work done during most of working life. DO NOT use retired) Nursing Assistant Nursing Home								
05	9	filed y Hygie other ent, II	Be Co	17. Father's Name (First, Midd	le, Last)			arbing			e (First, Middle		oert or Town, State, Zip Code) Maryland 21040 ocation - City or Town, State				
7	/lan	should be filed within and Mental Hygiene. Is marked other than " sumatic event, I'm We	To B	William Wesl	William Wesley Peaker, Sr. Irene							Black, White, etc. Specify: Black 16b. Kind of Business/Industry Nursing Home Maiden Sumame) Gilbert er, City or Town, State, Zip Code) Mood, Maryland 21040 20c. Location - City or Town, State Middle River, MD ee, P.A. ee de Grace, Maryland Interval Between					
9/12/05	Maryland	12 sho h and l 7 is me treums		19a. Informant's Name/Relation Chantel Lee								-					
9	e,	Healt Healt tem 2		20a. Method of Disposition	daugneer	20b. P	lace of Dispos	ition (Name o	of		Date Date						
	OE	Pages nent of ant: If I		1 \text{\$\}}}}}\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\									Middle River, MD				
	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Iewis Street, Havre de Grace, Maryland Approximate Approximate Approximate										arvl and			
				23a. Part1. Enter the disease, shock, or heart failure. L	ist only one cause on e	ach line.							ice,	Interval between			
		Physician		Immediate Cause (Final disease or condition resulting in death)	_a	Steon	YEL	TIS,	FE	EFT	TACI	TE		33 DAK			
		/Medical Examiner		Due to (or as a consequence of): 15CHEMIC GANGRENE													
3			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	or as a consequ	onset and onset										
2		cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Pue to	or as a consequ	ranca of):	ME	- 4	-170	1/20	76 /					
10	8760,	sician sician burial	dicai E		Dag to	(or as a consequ	201100 01).										
0	9	a 문 는	ledic														
4	Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregna wirth 2 Petal mant at time of de	Ideath 3□	Ectopic pregn Other (specif				23d. Dat Mor	e of deliventh	ery Day Year			
T	o.	t the de by the a	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		94(11 5)_	Other (specii	y)					STORES OF THE STORES			
)EL	ds, P	res tha igned be del	þ	Part II. Other significant cond	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE ROVAL FAILURE HYPENTEUSION								a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?				
F	COL	law requii as been s 2 should	ompleted	HYPEMT													
~ 1	_ <u>~</u>		Com								perfo	2/2(No 1	leath?	2□ No			
(1)	Vita	i icien : Th certificate rector, pag	Be	25. Was case referred to med examiner?	Hospital						th (Check only						
X	of	g Phys er this eral di	n: To	1 Purpation 2 Envolupation 3 DOA 4 Nursing nome 5 Hesidence 6 Other (Specify)								у)					
4	sion	ending sath. or: Aft he fun	atio	E	stigation	in, Day Your,	Injury	М	1 Yes	2 □No							
0	Divis	or Att	ertification:		old not be 28e. Place build	of Injury - At hong, etc. (Specify	ome, farm, stro y)	eet, factory, of	fice			Street and Numb wn, State)	er or Rura	al Route Number,			
	1	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifier (Check only one)	lying Physician: To the cal Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at t restigation, in	he time, da my opinion,	te and place death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as s and due to	tated. o the cause(s)			
		To the within To the comple	Med	COL Circle and title of and	ilian a			29c. L	cense num	ber		29d. Date signed	(Month,	Day, Year)			
				M. NON	cons	of n	10,		08	09	6	SEPTEN	1BET	(15,4005			
				30. Name and address of pers	NON AKE	se of death (Item	1 23a) (Type, MJ	Print) / Z	5 Nr	MA	N ST.	BirA	M,A	12 21014			
		Sta Regist	ate rar	31. Date filed (Month, Day, Ye SEP 1 6	2005 (32. F	legistrar's Signa	ture free	٧									

			1 - For State Registrar	State of Maryland	l / Depa		t of H	ealth a				05	31860
	Dhuais		1. Decedent's Name (First, Middle, Last)				_			2. Date of Deat Month		Year	3. Time of Death
	Physici /Medi		TIMOTHY ALL							SEP 1	3 2005)	11:20 A ^M
	Examir	ner	4a. Facility Name (If not institution, give s NATIONAL NAVAL]			4b. City,		Location o			4c. County		
			5. Social Security Number 6. Sex			If Under		If Under 2		8 Date of Birth		TGOM	
	Funeral Director			IM 2□F 45	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, SEPT • 12	_{уваг)} ,1960		place (State or Foreign ntry) LINOIS
	ryland how		10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits
	Be-f s	cto	CA. SAN DIEGO	0		RAM	ONA						1 XYes 2 No
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show deal Existilitied at	Funeral Director	10e. Street and Number			10f. Zip				10	g. Citizen of V		ntry?
	eath	eral	16328 DELANO CO	OURT 12. Was Decedent Ever in U.S	12.1	Mas Dood		068	sin? (Snor	oity Van as Na		S.A.	and Indian
"	r fter d	표	1 □ Never Married 2 🏋 Married	Armed Forces?	- 1			n, Mexican	, Puerto P	cify Yes or No- Rican, etc.)	Yes or No- n, etc.) 14. Race - American II Black, White, etc.		
93	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1979 Year or Dates: 200	_	1 □ Yes 2	No.	Specify:			Specify		IITE
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygliene. Id other then "neturel", or Items 23e or 28e-f show event, I're Madical Ext. inter ast be nutified at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	ient's Usua kind of wor	k done d	urina most	of workin	0	6b. Kind of Bu	ısiness/Ir	ndustry
121	within ene. then	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT us	e retired)) -					
2	filed v Hygie other i		17. Father's Name (First, Middle, Last)	2		0.8	. NA		r's Name	(First, Middle, N		ENSE	<u> </u>
Maryland	should be filed withir and Mental Hygiene. s marked other then umetic event, I're M.	To Be	THOMAS E	DWIN PELNAR	SCH					ONCILE	GOODS	•	
ary	and Mand is mar	-	19a. Informant's Name/Relationship (Ty)			g Address	(Street a	nd Numbe		Route Number,			Code)
	27 in		SONYA PELNARSCI	H/WIFE	163	28 DE	LANO	COUR	T, R	AMONA,	CA. 920	68	
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		ice of Dispo			9)	Da	ate 2	Oc. Location -	City or T	own, State
Ë	Pages Iment of tent: It it jury or o		`4 □ Donation 5 □ Other (Specify)		MBERS	CREM	ATOR	Y 9	-14-	2005	RIVER	DALE	MD.
Baltimore,	permit, Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737										.A. 0737
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	GLIOBLASTO	MA MUI	TIFOR	RME						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):								
		- O	Sequentially list conditions,). Due to (or as a conseque	nce off:								
	uted 3 ansit	Examiner	of a my, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							- 1			
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):								
8760,	ate be nysicia he bu	cal		l									
9		Med	IF FEMALE:	376-330								1	
Box	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	eath 3	Ectopic pre	egnancy				23d. Date Mor		ery Day Y <i>e</i> ar
o	at the de by the a stached t	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	ıth 5□	Other (spe	ecify)				14101		Day Toal
σ.	that t ed by detac		Part II. Other significant conditions con	tributing to death but not result	ing in the ur	derlying ca	ause give	n in Part I.		23e. Did toba	acco use contr	ibute to ti	ne cause of death?
ds	uires signa lid be	d by	_		-								pably 4 Unknown
00	w require been si should b	lete								24a. Was an	24b. V	Vere auto	psy findings available
Vital Records,	: The la cate has page 2	ompleted								autopsy perform	ed? p	rior to co eath?	mpletion of cause of
ital	sicien: certitica rector, p	e C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes 2 (Check only one		☐Yes	2 □ No
of V	di S	To B	examiner? 1 ☐ Yes 2 🙀 No	ospital: 1 □tmpatient 2 □ El	R/Outpatien	3 DO				e 5□Resider		r (Specif	y)
			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury		Bc. Injury Work	at ?		3d. Describe how			
Sio	Attending r death. ector: After by the fune	icat	2										
Division	- 0	Certification;								City or Town,	eet and Numbe State)	er or Rura	il Route Number,
	spitel		29a. Certifier TX Certifying Phys	ician: To the best of my knowl	edge, death	occurred a	at the time	e. date and	l place, an	nd due to the cau	use(s) and mar	ner as s	ated
	ne Ho	edical	(Check only 2 Medical Examinone)	ner: On the basis of examination and manner stated.	n and/or inv	estigation,	in my opi	inion, death	h occurred	d at the time, dat	e and place, a	nd due to	the cause(s)
	To the Hospitel o within 24 hours aft To the Funerel Di completely tilled in	Me	29b. Signature and title of certifier			29c.	License	number			d. Date signed	4	Day, Year)
1	9+1		1h	All	17	0		6889			19/14/		
	€ "		30. Name and address of person who con	_	a) (Type, I		$N\lambda T$	ĪONAL	NAV	AL MEDIO		TER	ty in the
	_		PETER J. SEBENY	LT MC USN			BET	HESDA	MD :	20889-56	500		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 2005	32. Registrar's Signatu	GOS	W							

State of Maryland / Department of Health and Mental Hygien 0 0 5 31861 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** William Phillips Jr. George September 7: 35 AM 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgo macy Advantist Hospital Rockville Grove 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1959 Nebraska 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X**M 2□F 504-86-2934 Director 46 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits er then "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No by Funeral Director Md. Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11334 Bent Creek Terrace 20876 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Mayes 2 □ No If Yes, Give Year or Dates: 1987 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or iter any injury or other traumatic event, the Machinal Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist Federal Courts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William George Phillips Sr. Barbara LaBue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11334 Bent Creek Terr. Germantown, Md. 20876 Sherry L. Phillips (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Sept. 2005 19, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Germantown, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Malignant Plemal EFFUSJOW 5 days /Medical Due to (or as a consequence of): Examiner ultiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attanding Physician: : After this certification of tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2)000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 Shpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/10/05 D0063088 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP Kastogi, Mohit 8910 Medical 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 15 Registrar

			State of Maryland / Department of He 1- State Registra-AMEMD#1p=rMD9/15/05.FMW.McCo Certificate of D		((1115 31862
			1 - Registra-MEMD#1p=rMD9/15/05,BW,McCo Certificate of D 1. Decedent's Name (First, Middle, Last) TERRY POTTS		Reg. No	3. Time of Death
	Physicia	an	Patte Tame		Month Da	
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Death		. County of Death
н	Examin	er	Althea Woodland Nursing Home Silver	Spring	M	ontgomery
	Funeral		5 Social Security Number 6, Sex 7, Age (In vrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	Birthplace (State or Foreign Country)
	Director		214-42-2662 ^{1 M 2 F} 61 Yrs. Months Days	Hours Min. 6	Month, Day, Year, 6 / 0 3 / 1 9 4	14 Pennsylvania
	p		Usual Residence of Decedent			10d. Inside City Limits
	arylar show	_	10a. State 10b. County 10c. City, Town or Location MD MOntgomery Silver Spring			1 Tes 2 No
	8a-f	cto	TIB Honeyemen 1		10- 0	tizen of What Country?
	I within 72 hours after death with the Maryland liene. Then "natural", or Items 23e or 28e-f show the Medical Examinat must be notified at	Funeral Director	100. Street and Number 1000 Bellview Drive 107. Zip Code 2090	1	10g. C1	USA
	eath	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisp	panic Origin? (Specify	Yes or No-	14. Race - American Indian,
	fter d	F	Armed Forces? If Yes, specify Cuban,	, Mexican, Puerto Rica	in, etc.)	Black, White, etc. Specify: White
8	eli, o	þ	If Yes, Give 1 ☐ Yes 2 ♀ No Year or Dates:	Specify:		Specify: WILLE
21215-0036	72 hc natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupati (Specify only highest grade completed) 16i. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)	ion iring most of working	16b. K	(ind of Business/Industry
7	within lene. than "	μ	Elementary/Secondary (0-12) College (1-4or 5+)		tant A	ccounting
7	filed v Hygie Ithar t		12	18. Mother's Name (Fin		
Maryland	be d la la la la la la la la la la la la la) Be		Margaret		
<u>Z</u>	2 should and Men Is marke aumatic	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an	nd Number or Rural Ro	oute Number, City	or Town, State, Zip Code)
S	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 Is marke any injury or other traumatic once.		Dowell Chow/Trustee 5427 Twin Kr	nolls Roa	d Colum	bia,Md 21045
Baltimore,	itam itam		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or Town, State
E	Page nent c	i	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cre	ematory 9	/9/05 B	eltsville,Md
aĦ	rmit. spartn porte y inju					SERVICE, P.A.
8	80E 29					Spring,Md20910
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician	8 8	Immediate Cause (Final disease or condition	rest	-	
	/Medical Examiner	1	resulting in death) Due to (or as a consequence of):	h. 11-		
		e e	Sequentially list conditions, January leading to the result of the sequence o	party		
	nsit	E	Sequentially list conditions, if any, leading to managinate cause. Enter Underlying Cause (Disease or injury	Carl	isc +	Grambule
Ć,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	ysicie	dical	d			
9	tifica ng ph as th	Medi	Trees.u.e			
Box	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of delivery Month Day Year
	at the dea by the at tached fo	Physiclan/Med	1 Use yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			,
P.0	that the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	ires tha signed I d be det	d by			1 ☐ Yes 2	Probably 4 ☑Unknown
ŏ	w require been si should b	ete			24a. Was an	24b. Were autopsy findings available
Re	has ge 2	Completed			autopsy performed?	prior to completion of cause of death?
g	iician: The l certificate ha rector, page	e Co	25. Was case referred to medical	26. Place of Death (Ci	1 ☐ Yes 2 🔯 N	o 1 Tes 2 No
₹	sicia certi	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other			6 ∏Other (Specify)
of	Attanding Physician: "r death. actor: After this certifica actor: After this certifica by the funeral director, p		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury Works	at 28d.	Describe how inju	
<u>io</u>	nding ath. r: Afte e fun	atlo		es 2 □No		
Division of Vital Records,	ospitel or Attandi hours after death. unaral Diractor: A ly filled in by the fo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
Ō	itel or irs aft ral Di			1		
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1	e, date and place, and inion, death occurred a	due to the cause(s at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	o tha ithin i o tha omple	Mec	29b. Signature and title of certifier 29c. License	number	29d. Da	ate signed (Month, Day, Year)
)	2		TAHMIMA K APANES DOO	60100	05	7-03-05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			Tahmina Ahmed MD. 7610 Carroll Avenue	Takoma Pa	ark.Md	20912
		ate	31. Date filed (Month, Day, Year) 339 Hegistrar's Signature			
	Regist	rar	SEP 15 2005 James J. Bossel			

			For State Registrar	State of M	laryland / [Departmen Certificat					giene		5	318	63
	Physici	an	Decedent's Name (First, Middle, L DAV		RD POWE	D.C.				2. Date of De Month	Da		ear	3. Time of I	
	/Medic Examin	al	4a. Facility Name (If not institution, g.				Town, or	r Location of	of Death	SEP 9		005 County of	Death	5:44	P _M
	EXAMIN	er	NATIONAL NAVAL			10.000		HESDA				MONT		ERY	
	Funeral			Sex 7. A 1 StM 2 ☐ F	ge (In yrs. last bir	Months	1 Year Days	If Under Hours	Min.	B. Date of Birt (Month, Da	y, Year)	9	. Birthp	lace (State or	Foreign
	Director		032-36-0383 Usual Residence of Decedent	, A	55	Yrs.			J	Jan. 17	, 19	950 0	Cali	lfornia	1
	ryland	L	10a. State 10b. County		10c. City, Tow								1	0d. Inside City	Limits
	he Ma 18a-f s	Director	Virginia Fairfa	X	Vienna		_							1 🗌 Yes	2010 2010 2010 2010 2010 2010 2010 2010
	with t		10e. Street and Number	Destaur		10f. Zip	2218	2			_	izen of Wha SA	at Cour	ntry?	
	death	nera	10211 Brittenford 11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Deced			igin? (Spec	ify Yes or No		14. Race -			
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-1 show ha Medical Examiner must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☑ Married	1 Types 2	^{]No} 1969−	1 ☐ Yes		Specify:		ican, etc.)		Black, Specify:		etc. nite	
Ö	Phour stural	ed p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates		Decedent's Usua		ation			16b K	ind of Busin			
215	thin 72 e. an "na Media	plet	(Specify only highest g			(Give kind of wo life. DO NOT u	rk done d	durina mosi	t of working	7	100.10	, i d oi o d oi i	103371110	20311 y	
21	led wii lygien her th it, the	Con	47 5 4 4 4 4 4 4 4	5±		inancial	P1a					rrill	Lyr	nch	
Maryland 21215-0036	d be fi	o Be	17. Father's Name (First, Middle, Las Arthur B. Powers							First, Middle,		Sumame)			
ary	shoul ind Me s mark umati	ဥ	19a. Informant's Name/Relationship		19b	. Mailing Address				Bogret		r Town, Sta	te, Zip	Code)	
Z,	and 2 saith a n 27 is		Kathie Ann Power	s/Wife	10	0211 Bri	tten	ford	Drive	, Vien	ına,	Virg:	inia	a 22182	h
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury presser traumatic evant, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	☐Removal from State	0000000	f Disposition (Narry, crematory or o	ne of ther plac	1	Da			cation - Cit			
Itim	artmen artmen ortant: injury		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lipo		Arling	gton Nat				,2005	Ar1	ingto	1, \	/irgini	.a
Ba	Depri Impo		> Have & De	anner		Money	& K	ing F	unera	l Home Vienna	, II	Nc.	180		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each	ed the death. Dor	not enter the mod	e of dying	g, such as	cardiac or	respiratory ar	rest,	1. <u>4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4</u>	.00	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. META	STATIC M	IELANOMA								Onset and De	aath
'n	/Medical Examiner		1 doubling in addition	Due to (or a	s a consequence	of):									
	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence	of):									
	and -transi	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for a		-f\.							-		
8760,	ate be executed hysician and the burial-transit	dical E		Due to (or a	s a consequence	01):									
9	tificate ig phys as the	ledic		0					1.00	*/					
Вох	ndir use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom- 1 ☐ Live birth	e of pregnancy 2 DFetal death	3 □Ectopic pr	egnancy				1	23d. Date o		*	
0	0 0	ysic	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of death	5 ☐ Other (sp	ecify)					Month		Day Ye	lati
<u>ര</u> പ	signed by	y Ph	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying c	ause give	en in Part I.		23e. Did to	bacco u	se contribu	te to th	e cause of dea	ath?
Zg	w require been sig should b						-			1 🗆 Y	es 2	∑No 3[] Proba	ably 4 □Un	known
Vital Record	2 8 8	Completed								24a. Was a autop	sy	prior	to con	osy findings av	ailable use of
a F			OS Was against a modical							perfor 1 Yes	2 X No	deal		2 No	
<u>=</u>	Physician: this certificanal director,	o Be	25. Was case referred to medical examiner? 1 Yes 2X No	Hospital: 1X Inpat	ient 2 ☐ ER/Qu	tpatient 3☐ DC	Othe			Check only or 5 □ Resid		Other (Snacifu	1	
n of		on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. T		8c. Injury Work	at		d. Describe h			эрөспу	/	
<u>S</u>	Attanding Ir death. actor: After by the fune	catle	2 Accident investigations in Suicide 6 Could not	on lead		М	1 🗆 ነ	res 2□1							
Division	for Attancatter death	Certificat	4 Homicide determine	28e. Place of Ir	ijury - At home, fa tc. (Specify)	rm, street, factory	, office		28	f. Location (S City or Tow	treet and n, State,	d Number o	r Rural	Route Numbe	ar,
	To tha Hospital or Attanding Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	dicalC	29a. Certifier (Check only 2 Medical Exa	hysician: To the best	of my knowledge	, death occurred	at the tim	e, date and	d place, and	d due to the c	ause(s)	and manne	r as sta	ated.	
	To tha H within 24 To the Fi	Medic	one)	miner: On the basis of and manner s	tated.				th occurred						
)	To will	-	29b. Signature and title of certifier	10	· · · · · · ·	290	. License	number 48 (NI	H)			e signed (N			
	12		30. Name and address of person who	completed cause of	death (Item 23a) (Type, Print)				VAL MEI	OG DICA	VL CEN		0	
			SEAN MACDERMOT		USAF					20889-			T TTL		
	Sta		31. Date filed (Month, Day, Year) SEP 15	32 Regist	rar's Signature	Sparke									
	Registr	ai	ULL TO	.000	w the										

ADH BERTHA PINKETT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-6223 State of Maryland / Department of Health and Mental Hygiene
1- State Unpend Item 23a,27,28a-f per me G850 12-2-05 tas
Registrar
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death SEPTEMBER 11, 2005 Physician Bertha inkett 0541 A M Woolford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER DORCHESTER GENERAL HOSPITAL CAMBRIDGE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-12-4516 Yrs. Nov. 29,1923 Director Maryland Usual Residence of Decedent 10d. fnside City Limits 10b County 10c. City, Town or Location 10a. State th and Mental Hygiene. ?7 is marked other than "neture!", or iteme 23a or 28a-1 eho: traumatic event, the Medical Examinar must be notified at 1 Yes 2 Tho Directo Dorchester MD am bridge 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2161 Road Dailsville by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Slatus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Garment Industry Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event once. Be James Woolford trances Dobson Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1915 Dails Ville Rd. Cambridge MD. 2/6/3
ce of Disposition (Name of Date 20c. Location City or Town, State Hemsley -inda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/17/05 Bucktown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cambridge 21. Signature of Funeral Service Licensee 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a Multiple Injuries with Complications /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ţ use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 XYes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28d. Describe how injury occurred
Passenger in vehicle involved 28a. Dale of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury al Work? 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Aff 1 Yes 2 No 9-6-05 4:00 in collision 6 Could not be 28f. Location (Street and Number or Bural Route Number, City or Town, State) J. S. Route 30 at Sunburst Highway, Cambridge, Dorchester County, MD 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the Pface of fnjury - At home, farm, streel, factory, office building, etc. (Specify) determined 4 Homicide fo the Hospital road 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title ∮ OCME SEPTEMBER 12, 2005

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who complete

31. Date filed (Month, Day, Year)

ed dause of death (ftem 23a) (Type, Print)

32. Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND, 21201

Physic /Medi	ian	1. Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Death Month Day Year 3. Time of D
		David Albert Hill Roethel	September 9, 2005 1:39
Exami	ner		ty, Town, or Location of Death 4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	Silver Spring Ver 1 Year If Under 24 H/S. 8. Date of Birth (Month, Day, Year) S Days Hours Min. (Month, Day, Year) S Birthplace (State or Country)
Director		388-22-1433 1 XM 2□F 79 Yrs. Months	s Days Hours Min. (Month, Day, Year) Country) Feb 17, 1926 Wisconsin
pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City
Maryie f sho	ō		1 □Yes
7.28a	Director	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Z	Zip Code 10g. Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Items 23a or 28a-f show enty injury or other treumatic event, the Marical Examination in any injury or other treumatic event, the Marical Examination in any injury or other treumatic event, the Marical Examination in any injury or other treumatic event.	al D	13218 Bregman Rd	20904 USA
r dea	Funeral		pedent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
s affe	by Fu	1 Never Married 2 Married 1 Tyes 2 No 1 Wes, Give 1 Yes	2 No Specify: Specify:
aturel		3 ☐ Wildowed 4 12 Divorced Year or Dates: WWII 15. Decedent's Education 16a. Decedent's Usi	white sual Occupation 16b. Kind of Business/Industry
nin /2	Completed		work done during most of working
er the	Con	5+ Executive	e Officer Trade Association
tal Hydra	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
hould d Mer marke matic	2	Albert John Roethel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Elsie Margaret Hill
th an		Elizabeth R. Nickless/daughter 9201 Heat	ss (Street and Number or Rural Route Number, City or Town, State, Zip Code)
f Healitem		20a. Method of Disposition (Na	Jame of Date 20c. Location - City or Town, State
Page in the ge			Crematory 9/17/2005 Brentwood, M
permit. Departm Importa eny inju		21. Signature of Funeral Service Licensee 22. Name a	and Address of Facility Hines-Rinaldi Funeral Home
8 8 8 8			New Hampshire Ave, Silver Spring, MD 20
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.	ode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
nysician	1	Immediate Cause Final disease or o Holdion resulting in death) a. Left Hip Fracture resulting in death)	Onset and De
/Medical Examiner		Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to infinite cause. Enter Underlying Cause (Disease or injury	Disease
cuteu nd ransit	Examiner	that initiated events c CIIFOILE Pullifoliary	v Disease
rate be executed hysician and the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):	
certificate be executed nding physician and use as the burial-transit	dica	d Prostate Cancer	
eath certific attending p for use as f	Physician/Medicai	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
death e atten ed for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (s	pregnancy Month Day Ve
the the	hys	9 ☐ Unknown 9 ☐ Unknown	
by l	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I. 23e. Did tobacco use contribute to the cause of dea
es tnat the death gned by the atte be detached for r		Gait Disturbance	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ini
es De de			24a. Was an autopsy findings av prior to completion of cau
v requires been sigr should be	npie		adiopsy prior to completion of cau
v requires been sigr should be	Completed		performed? death? 1 Yes 2 No 1 Yes 2 No
v requires been sigr should be	Be	25. Was case referred to medical examiner? Hospital:	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death Check on one
v requires been sigr should be	To Be	examiner? 1 🕱 Yes 2 🗆 No Hospital: 1 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗀 Di	performed? death? 1
ong rnysicien: The law requires After this certificate has been sign funeral director, page 2 should be	To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 December 27. Manner of Death 1 Shatural 5 Pending 28a. Date of Injury (Month, Day Year) (Month, Day Year) (Month, Day Year) (Month, Day Year) (Month, Day Year) (Month, Day Year) (Month, Day Year)	performed? death? 1 Yes 2 No 1 Yes 2 No No No No No No No
ong rnysicien: The law requires After this certificate has been sign funeral director, page 2 should be	To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 D 27. Manner of Death 1 X Natural 2 Death 1 X Natural 2 Death 1 X Natural 3 Death 1 X Natural 3 Death 1 X Natural 3 Death 1 X Natural 3 Death 1 X Natural 3 Death 2 EP/Outpatient 3 D 2 EP	performed? death? 1 Yes 2 No 1 Yes 2 No No No No No No No
ong rnysicien: The law requires After this certificate has been sign funeral director, page 2 should be	Certification: To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D 27 Manner of Death 1 Natural 5 Pending investigation 2 Stockhold investigation 3 Suicide 6 Could not be	performed? death? 1 Yes 2 No 1 Yes 2 No No No No No No No
nospital or Attending Prystoren: The law fequires thous after death. Funerel Director: After this certificate has been sign sly filled in by the funeral director, page 2 should be	Certification: To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D 27. Manner of Death 1 X Natural 2 Could not be determined learning investigation 4 Homicide 28a. Date of Injury (Month, Day Year) 8/15/2005 28b. Time of Injury Unknown 28b. Time of Injury Unknown 28b. Time of Injury Unknown 28b. Time of Injury At home 28c. Cypecify) At home	performed? death? 1 Yes 2 No 1 Yes 2 No No No No No No No
nospital or Attending Prystoren: The law fequires thous after death. Funerel Director: After this certificate has been sign sly filled in by the funeral director, page 2 should be	To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D 27 Manner of Death 1 X Natural 2 Codent 3 Dending investigation 6 Could not be determined 1 Note: 1	performed? 1 Yes 2 No
or Attending Prystolen: The law fequires fifter death. Director: After this certificate has been sign in by the funeral director, page 2 should be	edical Certification; To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D 27. Manner of Death 1 Natural 2 Detected No. 1 Suicide 4 Homicide	performed? death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death Check on one OCA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No While reaching for phone a home. He did not 1 SS CONSC Ory, office 28f. Location (Street and Number or Fural Rouse Number City or Town, State) 13218 Bregman Silver Spring, MD 20904 Order that the time, date and place, and due to the cause(s) Order that Orde
nospital or Attending Prystoren: The law fequires thous after death. Funerel Director: After this certificate has been sign sly filled in by the funeral director, page 2 should be	edical Certification; To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D 27 Manner of Death 1 X Natural 2 Codent 3 Dending investigation 6 Could not be determined 1 Note: 1	performed? 1 Yes 2 No
Thousafter death. Funerel Director: After this certificate has been sign ely filled in by the funeral director, page 2 should be	edical Certification; To Be	examiner? 1 X Yes 2 No Note that I I I I I I I I I I I I I I I I I I I	performed? death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death Check on one OCA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No While reaching for phone a home. He did not 1 SS CONSC Ory, office 28f. Location (Street and Number or Fural Rouse Number City or Town, State) 13218 Bregman Silver Spring, MD 20904 Order that the time, date and place, and due to the cause(s) Order that Orde

			1 - For State Registrar	State o	f Maryla	nd / Depa	artmer rtificat	nt of He te of D	ealth an	d Mental F	lygieme Reg. No	000	31866
0	Physici /Medic		Decedent's Name (First, Middle, I Jean A	.ast) • Robins	on					2. Date of Month Septem	Da	y 2005	3. Time of Death 4:30 p- M
7	Examir		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City,	, Town, or L	ocation of D	eath	4c.	County of Deat	h
и			Fox Chase Nursi	ng Home			Silv	ver Sp	ring			Montgom	ery
	Funeral Director		5. Social Security Number 6. 579–36–1648	Sex 1 □ M 2 🗷 F	7. Age (In yrs	6. last birthday)	If Unde Months		Hours N	lin. (Month,	Birth Day, Year)	Co	hplace (State or Foreign untry) higan
	pu ,		Usual Residence of Decedent		40- 0	. T							
	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "natural", or Items 23a or 28a-f show event, the Medical Evertiner must be natified at	rector	Maryland Montgo 10e. Street and Number	mery	100.0	Silver	Spri	ing Code			10g Cit	izen of What Co	10d. Inside City Limits TX☐ Yes 2☐ No
	with Sa or	0	2710 Northwest	C+				0901				S.A.	unity:
	ter death Items 23 Iner mus	Funeral Director	11. Marital Status 11 Never Married 2 Married	12. Was Dec		U.S. 13. Y	Was Dece	dent of Hisp	oanic Origin? Mexican, Po	(Specify Yes or Jerto Rican, etc.)		14. Race - Amer Black, White	
-003	hours at	by	3 Widowed 4 Divorced	Year or D	ve		1 Yes	2€ No al Occupatio	Specify:		16h Ki	Specify: B:	lack
21215-0036	within 72 ene. then "ns	Completed	(Specify only highest of Elementary/Secondary (0-12)		1-4or 5+)	(Give	kind of wo DO NOT u	ork done dur ise retired)	ring most of	working			,
	filed Hygi other		17. Father's Name (First, Middle, La.	st)		FI	15510	onary	8. Mother's I	Name (First, Mide		Religion Sumame)	us
Maryland	should be filed withir na Mental Hygiene. marked other then metic event, I's M	To Be	Unobtain							Unobtain	able		
	and 2 sh alth and 1.27 io m er troum		19a. Informant's Name/Relationship Fred Robinson/g:		hew		-			Rural Route Nur e Charlo	-		
nore	ages 1 and of He and of He rt. If item y or other		20a. Method of Disposition 1		State	Place of Dispo	natory or o	other place)	Q /	Date 19/2005		traced	•
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 ie marked eny injury or other treumetic e once.	1	21. Signature of Funeral Service Li		FOI	22	. Name ar	nd Address	of Facility	ort Linc	oln F	uneral I	Home
			23a. Part. Enter the disease, or co	molications that of	aucad the dea					Rd. Bren		, MD 201	Approximate
	Pnysician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on e	terine	Cancer	er trie mod	Je or dying,	sucii as care	Jiac or respiratory	, allest,		Interval Between Onset and Death
	Examiner			Due to	(or as a conse	quence ot):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (15.55.5) in y that initiated events	b. Due to	(or as a conse	quence of):							
68760,	ficate be executed physician and is the burial-transit	edical Exa	resulting in death) Last	Due to	(or as a conse	quence of):							
	eath certifica attending ph for use as t	-	IF FEMALE:	23c. If yes, out	come of pregr	nancv						204 8-1	
.O. Box	0 0	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Tho	1 Live b	oirth 2 Fet nant at time of	aldeath 3	Ectopic p Other (sp				-	23d. Date of delin Month	Day Year
Δ.	requires that the de een signed by the a nould be detached t	by	Part II. Other significant conditions Dementia		eath but not re	sulting in the ur	nderlying o	cause given i	in Part I.				the cause of death?
Records,	e law has b je 2 sl	Completed					, ₁ , ,			24a. W	as an topsy rformed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
a											2 No	1 Yes	2₹ No
Vital	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Other	-138	Death (Check onl			
of	ding Ph h. After th funeral	ıtlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date (Mon	npatient 2 Confinence of Injury th, Day Year)	28b. Time of Injury		28c. Injury at Work?		g Home 5 Re 28d. Describ			ify)
Division		Certification:	3 Suicide 6 Could not determine	d 286. Place	of Injury - At h	nome, farm, stre	eet, factory	y, office			(Street and own, State)		ral Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 X Certifying F	Physician: To the aminer: On the band man	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred restigation	at the time, , in my opini	date and plation, death or	ace, and due to the	ne cause(s) e, date and	and manner as place, and due t	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				290	c. License n	umber		29d. Date	e signed (Month,	Day, Year)
7	6		Brigh					D28	656		Sep	ptember	12, 2005
1	-(1)		30. Name and address of person who Ravi Passi MD					Silve	r Spri	ing, MD	20910		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1, 6 2005			ature				_			

			For State Registrar		5	State o	of Mar	yland / De <i>C</i>	partmen ertificat					giene Reg. No.	05	318	67
			Decedent's Name	e (First, Middl	e, Last)					-	504177		2. Oate of De	ath		3. Time of D	<u> </u>
	Physici /Medic		Paz Ade	ela Rey	yes D	e Gar	cia						$\operatorname{Sept}^{\scriptscriptstyleMonth}$	1 ² 4 ^y	2005	4:56 P) М
	Examin		4a. Facility Name (/	f not institution	n, give stre	et and nu	mber)		4b. City,	Town, or	r Location o	of Death		4c. Coun	ty of Death		
				an Hosp						3ethe				Mc	ntgom		
	Funeral Director		5. Social Security N 578-70-6		6. Sex 1 ☐ M	2 X F	7. Age (i	In yrs. last birthda 77 Yrs.	y) If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da	th Year) 4,1928	9. Birth	place (State or I	Foreign
			Usual Residence of					//				ı	Jan. Z	4,1928	Mexi	co	
	yland		10a. State	10b. County	•		1	Oc. City, Town or	Location							0d. Inside City	Limits
	e Mar ta-fal	ctor	MD	Prince	e Geo	rge's	5		Bowie							1 ☐XYes 2	! □ No
	ith the	Director	10e. Street and Nur	mber					10f. Zip	Code				10g. Citizen o	What Cou	ntry?	
	ath w			Emory (207				Mexi	.co		
	ler de Items	Funeral	11. Marital Status	ind OM Mar		Armed Fo	orces?	er in U.S.	If Yes, spec	dent of Hi cify Cuba	ispanic Oric ın, Mexican	gin? (Spec 1, Puerto Ri	ify Yes or No ican, etc.)	14. Ra	ace - Americack, White,		
336	urs af	by F	1 🗋 Never Marri 3 🗌 Widowed		iea	1 ☐ Yes If Yes, Gi Year or D	ve		1X Yes	2□ No	Specify:	Me:	xican	Spec	^{ify:} Whi	te	
Õ	72 hol	ted	/0	15. Deceden	t's Educat	ion (, , , ,		16a. De	edent's Usua	al Occupa	ation			16b. Kind of			
21	ithin 7	Completed	Elementary/Seco	ondary (0-12)	st grade c	College (1-4or 5+)	life	e kind of wor DO NOT us	se retired	during most ()	t ot working	7				
2	led willygien her th		12						Homema	aker					home		
and	lbe fi	Be	17. Father's Name		Last)									Maiden Suma	me)		
<u> </u>	hould d Me mark matic	²	Manuel 19a. Informant's Na		hin /Tyne	Print)		10h Ma	iling Address	/Stroot			ia San	cnez er, City or Town	- Ct-t- 7/-	C- (-)	
ĕ	od 2 s lith an 27 is 'treu		Adela Ga			. ′	iahte		2 Emor				, MD.	20716	7, State, ZIP	Code)	
ē,	s 1 ar f Hea item other		20a. Method of Disp	position				20b. Place of Dis				Dai	-	20c. Location	- City or To	own, State	
Ě	Page nent o nrt: If		1 ☐ Burial 2 (`4 ☐ Donation			oval from	State	Metropo]				09/1	7/2005	Alexa	ndria	. VA	
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28a-1 show eny injury or other treumatic event, I'm Medical Examinating the rediffed at once.		21. Signature of Fu	neral Service	Licenses		01		22. Na <i>m</i> e an	d Addres	s of Facility	y Bea.	11 Fun	eral Ho	me	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
-	90 E 9 9		1	Buar	-1	rue	er_		6512 N	W Cı	rain F	Hwy.	Bowi	e, MD.	2071	6	
			23a. Part1. Enter the shock, or hear	he disease, or rt failure. List	complicat only one o	tions that of	aused the	e death. Do not e	i		g, such as o	cardiac or i	respiratory ar	rest,		Approximate Interval Between	en
	Physician		Immediate Cause (disease or condition resulting in death)	Final n	a		Sel	be S	nou	· .						Onset and Dea	ath
	/Medical Examiner		resulting in death)			Due to	(or as	onsequence of):	- ^ 0								
		er	Sequentially list con	nditions,	b	Due to	(or as a co	onsequence of):		-	^			-			
2	uted	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	nying injury	S		COX) Works	trai	1	IN	rec	ney				
0,0	an an rial-tr	Еха	resulting in death) L	ast	C.	Due to	(or as a co	onseque ce c):	trai raaul			U .	1 /				
9 6	icate be executed physician and ithe burial-transit	dlcal			d.		ere	b-00-1	ranul	erd	a	CU C	en"				
12 8	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:														
7/2 Bo)	eath certific attending p	lan/Me	23b. Was decedent in the past 12		23c.		irth 2	Fetal death 3	□Ectopic pre			Section.		1	ate of delive	ry Day Yea	ar
, 0	tt the de by the a tached	Physici	1 ☐ Yes 2 🕽 9 ☐ Unknown	\$ No		4∐Pregr 9☐ Unkn		e of death 5	Other (spe	ecify)					O-141	, oa	
25	that the	by Ph	Part II. Other signifi	icant condition	ns contrib	outing to d	eath but n	ot resulting in the	underlying ca	ause give	n in Part I.		23e. Did to	bacco use con	tribute to th	e cause of deal	th?
/ <i>ių c</i> ords,	quires an sign uld be	q pa		Torbet	es	72	Tre	\overline{T}					1 🗆 Y	es 20/No	3 🗌 Prob	ably 4 □Unk	nown
9// Reco	aw requir is been si 2 should	plet	H	Mess	ener	es (24a. Was		Were auto	osy findings ava	ailable
		Completed	/	TUV	100	UN	m'n						autop perfor	med?	death?	npletion of caus 2□ No	e of
& Vital	icien: Th	Be (25. Was case reference	to medical							26. Place	of Death (Check only o	1			
35	hys this	ို	1 Yes 2		Hosp	PS.	npatient	2 ER/Outpati			4 INUIS	sing Home	5 🗆 Resid	ence 6 🗀 Otl	ner (Specify	•)	
120	ding F	lon	27. Manner of Death Natural	5 🗋 Pendin		28a. Date (Mon	of Injury th, Day Ye	ear) 28b. Time Injury		8c. Injury Work			d. Describe h	ow injury occur	rred		
isi	Attending r death. ector: After	ficat	2 Accident 3 Suicide	investig 6 ☐ Could r	ot be	28e Place	of Injury	- At home farm	M treet factory		′es 2□N		f Location /S	treet and Num	har or Pum	Route Number	
DIVI	after d after d Direct	Certification;	4 🗋 Homicide	determi	ined	buildi	ng, etc. (S	- At home, farm, s Specify)	rioot, lactory,	, onice		201	City or Tow	n, State)	ooi oi nuia	noute rumber	
M	id 10 10 11		29a. Certifier	Certifyin	g Physicia	an: To the	best of m	ny knowledge, dea	ith occurred a	at the time	e, date and	place, and	d due to the o	ause(s) and m	anner as st	ated.	
$\sigma_{\!\scriptscriptstyle A}$	To the Hos within 24 ho To the Fun completely	edical	(Check only one)	Z Medical		and man	ner stated	amination and/or									
	To the within 2 To the complet	Σ	29b. Signature and	itle of certifier	1100	de-	/		29c.	. License	number 7/0	91	2	29d. Date signe	d (Month, L	Day, Year)	
	(2)		1	1/2/	/ 02					1)	> >0	/)		59	4 13	· covs	
CR_	(3)		HITTY	1 125	who comp	leted caus	e of death	n (Item-23a) (Type	, Print) 1)ev	NOU	rong	BN	d, B	essesse	a, m	0.200	\$17,
	Star Registra		31. Date filed (Month	1.6 20	005	Sign R	egistrar's	Signature	de		U						

			1 - For State Registrar	State of N		epartmen Certificat			d Mental Hyg	jiene eg. No.	005	31	868
ı	Physic		1. Decedent's Name (First, Middle, La. O.C. Reese	st)					2. Date of Dea Month Sept.	Day	2005		of Death AM M
	/Medi Exami		4a. Facility Name (If not institution, give	e street and numbe	r)	4b. City,	Town, or	Location of De			ounty of Death		Ari
			Springbrook Adve	ntist Nur	sing Home	sil	ver	Spring		Mo	ntgomer	y Co.	
	Funeral Director		247-44-2090		kge (In yrs. last birti 88	frs. If Under Months	1 Year Days	If Under 24 H	lrs. 8. Date of Birth (Month, Day July 14	Year)	9. Birth	olace (State ntry) h Car	e or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside	City Limits
	Mary I-f sh	ţ	MD Montgome	ery Co.	Hyatt	sville							es 2 No
	th the or 28g	Director	10e. Street and Number			10f. Zip	Code		1	0g. Citize	n of What Cou	ntry?	
	23a (23a ust b	ra D	5718 Cypress Cree	ek Drive	apt. 203	3 2	0782			USA	A		
21215-0036	d within 72 hours after death with the Maryland jiene. r than "naturel", or Itams 23a or 28a-f show the Medical Examinar must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 □ Yes 2 15 If Yes, Give Year or Dates	5?] No	13. Was Decedif Yes, specific Yes		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		Black, White,	etc.	
5-	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>		Decedent's Usua (Give kind of wo	rk done d	uring most of t	vorking	16b. Kind	of Business/In	dustry	
12	within ene.	dwo	Elementary/Secondary (0-12)	College (1-4o	r 5+)	ilite. DO NOT u: ty Main t			kor	Сот	ernment	_	
d 2	Hyg it,		17. Father's Name (First, Middle, Last)		01	ty Hain	спаг		lame (First, Middle,			-	
lan	o d a b	To Be	Hayes Reese						Robinson				
Maryland	d b E E	-	19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing Address	(Street a		Rural Route Number	City or T	own, State, Zip	Code) 20	77/3
Σ	ロモトコ		Cleopatra Tibbs/	Daughter	120	07 Addis	son F	load ap	t. 460 Cap	itol	Height	s, M) 43
Baltimore,			20a. Method of Disposition 12 Burial 2 Cremation 3		P [Disposition (Name, crematory or o			1		tion - City or To		
틆			* 4 □ Donation 5 □ Other (Specify 21. Sign ture of Tuneral Service Licen		Lincol				t.15,2005 ohnson and				Uomo
Ba	permit. Departr Importe any inju	45 1	* tasula	BA	der				NW Washing				L HOME
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	olications that cause	ed the death. Do no						20 200	Approxim	ate
	Physician	v 1	Immediate Cause (Final disease or condition		ULAR ARRE							Interval B	
	/Medical		resulting in death)	a	s a consequence of								
	Examiner		Sequentially list conditions,	b									
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of	f):							
	al-trar	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of	n);	_						
8760,	icate be executed physicien and s the burial-transit	dlcal E		4									
89	g phy as the	edle		d.									
Вох	death certificate be executed e attending physicien and of for use as the burial-transit	M/m	200. Tras decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death	205-1				23d	. Date of delive	ery	
		sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	3 □Ectopic pro 5 □ Other (spo					Month	Day	Year
P.	that the de ed by the a detached	Physician/Me	9 🗆 Unknown										
Vital Records,	w requires that the been signed by th should be detache	Completed by	Part II. Dther significant conditions of DEMENTIA	onthouting to death	but not resulting in	the underlying ca	ause give	n in Part I.		acco use s 2□N	contribute to th	e cause of ably 4 X	
Sec.	aw is to	nple							24a. Was ar autops	/	4b. Were autop	osy findings	s available cause of
a E	ilcien: The l certificate ha ector, page								perform 1 ☐ Yes 2	ied? X ∃No	death? 1 ☐ Yes	2□ No	
₹		Be	25. Was case referred to medical examiner?	Hospital:			Other		eath Check only one				
ō	Phys or this oral di	. To	1 ☐ Yes 2X No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, Date			A	4 LA Nursing	Home 5 Reside			')	
on	Attending or death. ector: After by the funer	atlor	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Inj	ury M	Bc. Injury Work¹ 1 ☐ Y	? es 2 □ No	400.000.000.00	i iiijaiy oo	,00,100		
<u></u>	l or Attenc after death Director: in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	289. Place of it	jury - At home, fam tc. <i>(Specify)</i>	n, street, factory	, office		28f. Location (Str City or Town	eet and N State)	umber or Rura	Route Nur	mber,
_	Hospita 4 hours Funarel rely filled	Medical Ce	Z Intedical Casti	men. On the pasis (of examination and	death occurred a	at the time in my opi	, date and pla nion, death oc	ce, and due to the ca curred at the time, da	use(s) and	d manner as sta	ated.	(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	rated.		License				grijed (Month) L		
^	- s + ŏ						1	611	17	9	14	()V	
1	(5)		30. Name and ddress of person who c					100			1 /		
	Sta	te	Nasreen Kango,	The second second	Carroll . rar's Signature	Ave. Su:	ite 2	205 Tak	oma Park,	MD 2	0912		
	Registr		SEP 1,6 2005		KA	and I							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ADRIAN WILLIAM REYNOLDS September 16, 2005 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 511 Wilson Place Frederick Frederick 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Year) Director 186-14-0613 82 1924 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location show 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23a or 28a-f shov othar traumatic avent, the Madical Experiencer aust be notified at 1 Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Wilson Place 21701 U.S.A. by Funeral death 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural, or itan any injury or othar traumatic avent, the Madical Exactive and. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Lineman & Engineer C&P Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Reynolds Millie Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Reynolds (Son) PO Box 129, Woodsboro, Maryland 21798 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 9/19/2005 ' 4 ☐ Donation 5 ☐ Other (Se Frederick, Maryland 21. Signature of Funeral Servi License ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aut disease or condition resulting in death) Onesute /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Little Unionlying Cause (Disease or injury Examiner Due to (or as a consequence of): requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 ☐ Yes 2 to Mo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2□ No 24-1NO 1 Tyes the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 70 1 Yes 2 No After this funeral dir 1 🗌 Inpatient 2 ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) p hours after 4 Homicide fo the within 24 hours ha Funeral D 1 Decertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title 0) certifier 29c. License number 29d. Date signed (Month, Day, Year) ren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9th SI: Frederick Md 4701 300 W rancis 12. Hecker -MD 32 legistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2005 Registrar

			1 For State	State of	Maryland /	Depa	rtment tificate	of H	ealth a	and Me	ental Hy	giene	005	318	70
			Registrar 1. Decedent's Name (First, Middle,	(201)		Cert	lineale	OIL	Jeani		2. Date of De	Reg. No.		3. Time of	Death
	Physici	an									Month	Day		r .	a M
	/Medi	cal	Josefa Ca 4a. Facility Name (If not institution,	ridad	Snayder		4b. City, T	Fown or	Location (eptemb		5 2005 County of De		<u>a</u>
	Examir	ner	Montgomery Hosp				Rock			oi Deatti			ntgome		
	-				7. Age (In yrs. last I	oirthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birl			irthplace (State o	r Foreign
	Funeral Director		217-42-0590	1 ☐ M 2 🔀 F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da ept. 8	y, Year) 193	36 C	ountry) ` uba	
	D		Usual Residence of Decedent												
	how	_	10a. State 10b. County		10c. City, To	wn or Loc	cation							10d. Inside Ci	-
	8e-1 s	cto	Maryland Montgo	mery	Sil	ver	Sprin							1 Tyes	2 €□ 140
	ith th	Dire	10e. Street and Number	3	#101		10f. Zip	Code 209	106			10g. Citi	izen of What (Country? ISA	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show the Medical Exami he notified at	Funeral Director	13521 Georgia			140.14				-1-0 (0					
	er de	nue	11. Marital Status	Armed Fo		13. Vi	Yes, speci	ent of His ify Cubai	n, Mexicar		ify Yes or No lican, etc.)	-	Black, Wh	nerican Indian, nite, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Giv	ө	1:	Yes 2	□ No	Specify:	Cub	an		Specify:	White	
21215-0036	thou ature	Completed by	15. Decedent's		16	a. Decede	ent's Usual	l Occupa	ition			16b. Kii	ind of Busines	s/Industry	
215	n "n	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	-4or 5+)	(Give k	kind of worl OO NOT use	k done d e retired,	<i>uring</i> mos	t of workin	g				
21	d with	mo	8	00090 (Man.	icuri	st				Co	smetol	ogy	
pu	al Hy I othe	Be (17. Father's Name (First, Middle, La	ast)							(First, Middle,				
<u> </u>	Ment Ment arked	2	Juan Miguel Ch	navez					Pr	oscop	ia Bal	doqu	iin		
Maryland	2 sho and is m		19a. Informant's Name/Relationship				-	•				-	r Town, State Clorida		
ر ح	and fealth m 27 her ti		Aminta Maria Mo	ontanez/	20b. Place				IL DI		Naval I			or Town, State	
lor	ges High		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from	State ceme	tery, crem	atory or oti	her place	1	Sept.		200. LO	oation - Oity c	i romi, stato	
Baltimore,	t. Pa		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li 		Metrop					20	05	Alex	andria	, Virgin	nia
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show eny injury or other treumatic event. I've Medical Examinar institute an ordinate and once.		23a. Part1. Enter the disease, or c	- Jan	2	5	00 Un	iver	sity	Blvc	l, W, S	ilve	ome Inc er Spri	ng, MD 2	20901
760,	Physician //Medical Examiner physician and physician and physician and physician and physician are perfectly as a second of the physician and physician are perfectly as a second of the physician ar	licai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (Stage Ren or as a consequenc or as a consequenc or as a consequenc	e of):	iseas	se						Onset and D	
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnancy irth 2 Fetal dea ant at time of death own		Ectopic pre Other (spe					2	23d. Date of d Month		/ear
	ires that signed b	Completed by PI	Part II. Other significant condition Cirrhosis	s contributing to de	eath but not resulting	in the un	derlying ca	use give	n in Part I					to the cause of d	
Records,	w require been si should I	ete									24a. Was	an	24b. Were	autopsy findings	available
Re	sicien: The law certificate has b irector, page 2 s	du									autor perfo	rmed?	prior to death?	completion of ca	ause of
Vital		CO	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o		1 □ Y∈	s 2 No	
5	Physicien: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 ER/0	Outpatient	3□ DO	A Othe	-				5 ♥ Other (Sp	ecify.Hospic	ce
of		I	27. Manner of Death			. Time of Injury		3c. Injury Work			3d. Describe I			,,,100p1	
ion	Attending F r death. sctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investiga	1	n, Bay roar	injury	М		es 2 🗆	No					
Division	r Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place	of Injury - At home, ng, etc. (Specify)	farm, stre	et, factory,	office		2	Bf. Location (5 City or Tox	Street and vn, State)	d Number or i	Rural Route Num	ber,
Ö	rs afte	Cer													
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical			best of my knowled asis of examination a ner stated.)
	To th withir To th comp	Me	29b. Signature and title of certifier	J 11	ata: A	10	29c.		number	(2)		29d. Date	e signed (Moi	nth, Day, Year)	
	5		> Alicra	J. Jun	any 10	10		125	973	5 6		Sep	otember	15, 20	05
			30. Name and address of person w Alicia Mistry,	ho completed caus		a) (Type, F al Ce	enter	Dri	ve, F	lockv:	ille, M	1D 20	0850		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 16	2005 A	egistrar's Signature	Spa	Les .						-		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month William Fay Shires 14:08P M 13. September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Harkord 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 77 Director 217-20-2266 Yrs. February 12,1928 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumstic event, the Modical Examination ust be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 X No MD Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 2103 Colora Road Funeral 21917 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates: 1946-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7; in and Mental Hygiene. 7 is marked other then "n: Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herschel Shires <u>Grace Madron</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is rr any injury or other treum once. Ruth Shires/wife 2103 Colora Road, Colora, Maryland 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 09-19-2005 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cemetery Colora, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Interstitial Pulmonary FIBROSIS disease or condition resulting in death) Lyears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the a 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check on one examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051720 14th 2005 1321 Riverside PARKWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+IVA Johns Hookins At Richeside
32. Registrar's Signature Belcamp, md 21017 Registrar

			For State Registrar	State of	Maryland	-	artmen rtificate			and M	lental Hy	_	005	3187	13
	° Physici	an	1. Decedent's Name (First, Middle								2. Date of De Month Septem		Yes	3. Time of Do	
	/Medic	al	Telford Waide S 4a. Facility Name (If not institution		her)		4h City	Town or	Location of	of Dooth	Septem		26 200 County of D		A M
	Examin	er	13023 Pennsylv		301)		Hage			n Death			ashing		
	Funeral		5. Social Security Number 205–18–4128	6. Sex 7 1 1 M 2 ☐ F	. Age (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	24 Hrs Min.	8. Date of Bir (Month, Da Feb 2	th v. Year)	9.1	Birthplace (State or F Country)	oreign
	Director		Usual Residence of Decedent	A -	J.	, iis.					reb. Z	0 19	12 Pe	nnsýlvani	a
	aryland show	1	10a. State 10b. County			, Town or Lo		-						10d. Inside City	
	the Ma 28a-f	Director	Maryland Washi	ngton	Ная	gersto	WIN 10f. Zip	Codo			Т	10a Citi	zen of What	1 ☐ Yes 2	X
	3a or	I Dir		mda Arra				742				USA		Country?	
	ems 2	Funeral	13023 Pennsylva 11. Marital Status	12. Was Deced		S. 13.			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)			merican Indian,	
36	be filed within 72 hours after death with the Maryland ntal Hygiene. od other then "neturel", or items 23a or 28a-f show event, the Madical Exameration or infilied at	by Fu	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ried 1 Tyes 2	! ⊠ No	1	1 □ Yes 2			, 1 40110	Thousand, Oto.)		Specify: W		
9	2 hour	led b	15. Decedent	t's Education	es:	16a. Deced	ient's Usua	I Occupa	ation				nd of Busine		
215	within 7. ene. then "n	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1	tor 5+)	life. I	kind of wor DO NOT us	e retired,	luring mos)	t of worki		Truc	k	·	
121	e filed within Il Hygiene. other then vent, the Ma		12 17. Father's Name (First, Middle,	(act)		Insp	ector		19 Matha	de Alama	(First, Middle		factor	ing	
Maryland 21215-0036	ould be f Mental H arked ot atic ever	To Be	Harvey B. Seese								rthur	, маловп	Surname)		
ary	S E E	F	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a			l Route Numbe	er, City or	Town, State	e, Zip Code)	
	1 and 2 Health a em 27 is		Sally Starkey/D	aughter		38 Ba			St. (ncastle				
Baltimore,	m 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		ce ce	ace of Dispo emetery, cren t Have	natory or or	ther place		-29)ate			or Town, State	
Ħ	교육분류		4 □ Donation 5 □ Other (S_i21. Signature of Funeral Service		Res				1		t Haven	_	erstow		
ã	Departing Department on the property of the pr		> S. Amule	Sun							ve Hage				
i	70.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can	used the death ch line.	. Do not ent	er the mode	e of dying	g, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Between	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acute			/	NF	TI	N				Onset and Dea	
	Examiner			b. A. TE	r as a consequ	,			~ 7	DU 6	acc			V-74-1	
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dua to (o	ав в сипвион	ence of):	K IT	- m		110	120			7 GMZ	
V	cate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Dua to (o	r as a consequ	anas of									
8760,	sician buria	cal E	•	500 10 (0	1 43 4 CO1136QL	ionco or).									
9	tificate ig phy: as the	ed		d.								-			
Box	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal nt at time of de	death 3	Ectopic pro Other (spe					2	3d. Date of o	delivery Day Yea	ır
P.0	that the de led by the a detached f		9 ☐ Unknown Part II. Other significant condition			Iting in the u	adachina c	uco aiva	n in Part I		23a Did to	obacco III	ee contributo	to the cause of deat	h2
ds,	uires tha signed Id be det	d by	NONE	ons commoning to doe	ar bat not resu	iting in one di	idenying Ca	iusa giva	milirali,		1 🗆 `			Probably 4 ⊟Unk	
Records,	aw require is been si 2 should b	Completed									24a. Was	an	24b. Were	autopsy findings ava	ulable
- Re	9 4 9	omi										osy rmed? 2 No	prior to death 1 \(\text{Y}		se of
Vital	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	-				0.1			(Check only o				
ō	Phys this ral dii	- To	1 Yes 2 No		oatient 2 E	ER/Outpatien 28b. Time of		A Dine	at A 🗌 Nu		ne 5 PResid			oecify)	
ion	Attending Frideath.	ation	1 Natural 5 Pendin 2 Accident investig		Day Year)	Injury	м	Bc. Injury Work 1 🔲 Y	? ′es 2 🗀 l			iow injury	00001100		
Division	l or Attenation after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inod 286. Place 0	f Injury - At hor J, etc. (Specify	me, farm, str	eet, factory	, office		2	28f. Location (5 City or Tox			Rural Route Number	,
	Hospita 4 hours Funerel ely fillec		(Check only 2 Medical	ng Physician: To the b Examiner: On the bas	est of my knov	vledge, death	occurred a	at the tim	e, date an	d place, a	and due to the	cause(s) a	and manner	as stated.	
	To the within 2. To the f	Medical	one) 29b. Signature and title of certifier	and manne	r stated.			. License						nth, Day, Year)	
	F ≥ F 8		1 hum 8		MI				010	y,				6-2005	•
			1000	(100)	-				-10	70			. 4	- 2 - 0	
			30. Name and address of person	who completed cause	of death (Item	23а) (Туре,	Print)								
_	5		BARRY M CO.	HON, MD	322	6. A.		TAM	57	HA	6ERS 70	w n,	MD	21740	
	Sta Registr		BANRY M CO. 31. Date filed (Month, Day, Year)	HON, MD	322 Istrar's Signat	€, A.			47	HA	GERS TO	w N	MD	21740	

ORIGINAL

ltimore, Maryland 21215-0036 d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other then "ne is 1 and 2 s of Health an item 27 is permit. Pages 1
Department of H
Importent: If its
any injury or ot
ange.

Box 68760, P.O. Records,

use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed peeu ARMELLA Division of Vital 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 💢 No 2 XER/Outpatient 3 DOA ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t Certification: or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direct Hospital 29a. Certifier cal (Check only one) 29b. Signatura 29c. License number H0056771 30. Name a no completed cause of death (Item 23a) (Type, Print) 500 31. Date filed (Month, Day, 32. Registrar's Signature State 2005 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 24 **Physician** Carmella Sambuco 2306 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Havre de Grace
If Under 1 Year | If Under 24 Hrs. Harford Memorial Hospital Harford 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/7/1937 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Yrs. Director 67 205-28-1972 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 27 is marked other than "natural", or itama 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 XYes 2 ☐ No Director Burlington Mt. Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Newton Court 08054 U.S.A. Funera Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo þ Specify: White 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 <u>Real estate</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Romanelli Carmella Gregorio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Hullings (Daughter) 174 Schoolhouse Lane Mt. Laurel, NJ 08054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nothin temperat Calvary Mausoleum 9/28/05 Cherry Hill, NJ 21. Signature of Funeral Service License ²² Name and Address of Facility
Tarring-Cargo Funeral Home, P.
Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ACUTE MYDCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner ORONARY ARTERY DISEASE 10 YRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MiUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 ☐ No 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 26, 2005 Upper Gresapeaka Drive

		1 - State of Mar State of Mar Registrar	yland / Depa <i>Cei</i>	artment of Healt tificate of Dea	th and Ment ath	tal Hygien Rag. N	m 0 0 0	31875
Physic	ian	Decedent's Name (First, Middle, Last)				ate of Death	ay Year	3. Time of Death
/Med	ical	Dorothy Jane Smith			SEL	TEMBER	25 200	5 3:20AM
Exam	iner	4a. Fagility Name (If not institution, give street and number)		4b. City, Town, or Locat	1 1	4	C. County of Deat	h
Funera	7		(In yrs. last birthday)	If Under 1 Year If Ur	nde/ 24 Hrs. 8. D	ate of Birth	9. Birth	hplace (State or Foreign
Directo			80 Yrs.	Months Days Hou	urs Min. 1(A	ate of Birth Month, Day, Yea 0/19/192	4 New	intry) 7 Jersey
land		Usual Residence of Decedent 10a. State 10b. County 1	IOc. City, Town or Lo	cation				10d. Inside City Limits
with the Maryland a or 28a-f show the netiting at	to	Maryland Harford	Bel Air	-				1⊠Yes 2 No
th the	Director	10e. Street and Number		10f. Zip Code	•	10g. C	itizen of What Co	untry?
death wi	ral	118 Stoneleigh Rd.		21014			JSA	
15-0036 15-0136 "natural, or Items 238	Funeral	11. Marital Status 12. Was Decedent Even Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes % TyPo		Vas Decedent of Hispanio Yes, specify Cuban, Mex	c Origin? (Specify Y xican, Puerto Rican	res or No- , etc.)	14. Race - Amer Black, White	
5-0036 72 hours after natural; or tea	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🐉 ☐ No If Yes, Give Year or Dates:		☐ Yes 2 No Spe	cify:		Specify: Whi	.te
7 7 5-0 5-0 72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation	most of working	16b.	Kind of Business/I	
21215-0036 d within 72 hours all gine. The "natural", or ar then "natural", or ar then "natural", or ar then "natural", or ar then "natural", or ar then "natural", or ar then "natural", or ar then "natural".	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done during of NOT use retired) home maker	.		in home	
d 2	Be Co	12 U 17. Father's Name (First, Middle, Last)			lother's Name (Firs	t, Middle, Maide		·
IOPE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If it is marked other than "natural", or Itams 23a or 28a-1 shoor or other traumatic avant. If a Madical Examinetry as the natifical and or other traumatic avant.	To B	Alfred J. Sheaf		i	Dorothy	F. Hins	dale	
ore, Mary set 1 and 2 sho of Health and If friam 27 1s ma	1	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Nu				ip Code)
ore, M		JoAnn Watson (daughter) 20a. Method of Disposition	118 S 20b. Place of Dispos	Stoneleigh R	d., BelAi			
Baltimore, semit. Pages 1 at 3 spanithent of the mportant: if item more,		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other place) Iemorial Gard			_ocation - City or 1	
Baltimo pernit. Pages Deportment of Important: If i any injury or once.		21. Signature of Funeral Service Licenses		Pring Actarg5			•	arytand
Dal Depui		1 6 d 3. gll - 1		erdeen, Mar				
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	or the mode of dying, such	as cardiac or resp	piratory arrest,		Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	sander	starct	200			Onset and Death
Examiner		Due to (or as la to	consequence of):	Juden D	. 1	1 ()		1900000
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	thickes h	(nercy	direc	re	9+00
Cuted and transit	Examiner	that initiated events c.	myta					U-Par
60, be execician a		resulting in death) Last Due to (or as a c	consequence of):					
68760, ficate be execute physician and is the burial-trans	edical	d						
Box (eath certif		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of deliv	rery
O. B ne death the atte	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O. that the dead by the detached		9 ☑ Unknown Part II. Other significant conditions contributing to death but n	not regulting in the un	deshine sever siver is D	2	2a Did tabasa		
cords, P w requires that s been signed to should be det	d by	0 / /	Mescilling in the un	denying cause given in Pa	arti. 2		use contribute to	the cause of death? bably 4 Unknown
COT W req s been	ompleted				2	4a. Was an	24b Were aut	opsy findings available
Re(The lav	ошо					autopsy performed?	prior to co	ompletion of cause of
f Vital Reysician: The list certificate ha	Be C	25. Was case referred to medical examiner?		26. P	lace of Death Che	□ Yes 2.DM ck on one	To tes	2 NO
of V Physic this co	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient		Nursing Home 5			fy)
On C ding F h. After funera	tlon	27. Manner of Death 1 Shatural 5 Pending (Month, Day Young) 2 Accident Investigation	ear) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2		escribe how inju	ry occurred	
Division of Vital Records, lat or Attending Physician: The law requires the staffer death. In Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	ertification;	3 Suicide 6 Could not be 28e. Place of Injury	· At home, farm, stre		28f. Lo	cation (Street a	nd Number or Run	al Route Number,
Divination rs after all Direction led in leading	O	4 Homicide determined building, etc. (3	эрөсігу)		Ci	ty or Town, State	9)	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed tha Phours after death. The Funaral Director: After this certificate has been signed by the attending physician and inplacely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only (C	amination and/or inv	occurred at the time, date	and place, and du death occurred at t	e to the cause(s) and manner as s	stated. to the cause(s)
To tha Hos within 24 h To tha Fur completely	Med	one) and manner stated 29b. Signature and title of certifier	d. 	29c. License numb			ite signed (Month,	
F 3 F 8		Och Alle		020 0	275	91	27/05	
		30. Name and address of person who completed cause of deat	h (Item 23a) (Type)	Print)	00	1:	Unit !	
5		21 Date filed (Month Prix York)	Maclo	will a /2	el Am	Jun 2	1014	
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's	o signature	200				

. **		-	For State Registrar		of Maryl	and / Dep	ertificate	Health	and M	lental Hygi	ene 0 ()5 (31876
	sicia edic		1. Decedent's Name (First, Middle, Las Harvey Clift		h					2. Date of Death Month September	Day	Year	3. Time of Death
	ımine		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Tow	n, or Location	on of Death		4c. County		
			16526 Raven Rock 1					illas				deric	
Fune Direc			5. Social Security Number 6. S 217–28–1150	ex ⊡XM 2□F	7. Age (In)	yrs. last birthda Yrs.	Months Da		er 24 Hrs. S Min.	8. Date of Birth (Month, Day,	Year 929		e (State or Foreign
	lor		Usual Residence of Decedent							October	10,	Mary.	Land
ryland	9		10a. State 10b. County		10c.	. City, Town or	ocation					10d	. Inside City Limits
ith the Marylar or 28a-f show		cto	Maryland Frede	rick				lasvi	lle				1 ☐ Yes 2 X No
with th	8	Dire	10e. Street and Number 16526 Raven Rock	Dand			10f. Zip Cod	e 21780		10	og. Citizen of W	-	r?
eath	9	eral	11. Marital Status		edent Ever	in U.S. 13				ecity Yes or No-		S.A.	Indian.
ifter d		Funeral Director	1 Never Married 2 Married		2 □ No -	1952-	. Was Decedent If Yes, specify (Rican, etc.)		k, White, etc	
ilied within 72 hours after death with the Maryland Hygiene. Hygiene "naturel", or Itams 23a or 28a-f show		þ	3 Widowed 4 Divorced	If Yes, G Year or D	Dates:	1954	1 □ Yes 2 □X	No Speci	ify:		Specify	Whit	te
72 h	3	etec	15. Decedent's Ed (Specify only highest gra	ducation de completed))	16a. Dec (Giv	edent's Usual Oc re kind of work do DO NOT use re	cupation ne during m	nost of work	ing 1	16b. Kind of Bu	siness/Indus	stry
within ene. than	1	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ninist	urea)			Plasti	c Comr	nany
filed Hygi	an'.	0	17. Father's Name (First, Middle, Last)			1140		18. Mo	ther's Name	(First, Middle, N			Samy
uld be Mental	E BA	To B	Harry R. Smith						Janet	ta M. Ka	andall		
political et al. Paral y latter A. L. A. Permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than	omar Iraumaiic avan, ir a markai E.A. IIII al 1951 ce i killist a		19a. Informant's Name/Relationship (Type, Print)		19b. Ma	ling Address (Str	eet and Nun	mber or Rura	al Route Number,	City or Town,	State, Zîp Co	ode)
and and ealth m 27	an rec		Helen D. Smith (Wife)	- 1	-							and 21780
ges 1 t of H	010 10		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from	State	cemetery, cr	oosition (Name of ematory or other	olace)	1	Date 2005 2			
t. Partmen	dnuk		*4 □Donation 5 □Other (Specif		I		Cemetery		Septe	mber	Cascad	e, Mai	ryland
Deparition of the position of	any II		21. Signature of Funeral Service Licer	1500	•	0.	22. Name and Ad			J.L. Dav			
SECTE OF		-	231. Part1. Enter the disease, or com	plications that	caused the					Smiths or respiratory arre		A	pproximate
Physic /Medi	cal		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	lu	sequence of):	CONL	0/				٦,١	itérval Between inset and Death
Exami	-		Sequentially list conditions,	b		15							
√ ¹ 0	IIS I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a con	sequence of):							
axecul and	al-trar	xan	that initiated events resulting in death) Last	c. Due to	(or as a con	sequence of):							
cate be executed shysician and				d									
rtificat ng phy	as In	Medi	IF FEMALE:										
The law requires that the death certificate be executed at the bear signed by the attending physician and	ched for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 🗀 l nant at time	Fetal death 3	□Ectopic pregna □ Other (specify				23d. Date Mor	e of delivery nth Da	ay Year
s that	9 09(5	by PI	Part II. Other significant conditions of	ontributing to	death but not	resulting in the	underlying cause	given in Pa	ırt I.	23e. Did tob	acco use contr	ibute to the	cause of death?
w requires been sign	g pine	ed b	4 Corona	7	-	any	Hire	<u>u</u>		1 ☑ Ye	s 2□No	3 Probab	ly 4 □Unknown
law re	N	Completed	Chrone C	MST	met	wo &	ing !	YJL	er(24a. Was ar		Vere autopsy	/ findings available letion of cause of
The The ate h	page	Com					7			perform	ied? 📗 d	eath?	□ No
sician: The law	actor,	Be (25. Was case referred to medical examiner?	t to on the le					ace of Death	(Check only one	2)		34
Physi This o	al dire	10	1 ☐ Yes 2 No 27. Mann Death		-	2 ER/Outpati	BILL 3 DOW			me 5 Desider		or (Specify)	
ding Phys h. After this	Tuner	tlon	1 Natural 5 ☐ Pending		of Injury oth, Day Yea	(r) Injury		njury at Work? Yes 2	_	zod. Describe no	w injury occurre	90	1
Attanding r death.	y the	fica	3 Suicide 6 Could not b	e 28e, Plac	e of Injury -	At home, farm,	street, factory, offi			28f. Location (Str		er or Rural R	loute Number,
all Dire	<u>⊆</u>	Certification:	4 Homicide	build	ding, etc. (Sp	oecify)				City or Town,	State)		
To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifice	completely filled in by the Tuheral director, page	edical	29a. Certifier 1 Certifying Ph (Check gnly ong) 2 Medical Exar	niner: On the I	e best of my basis of exam one stated.	knowledge, de nination and/or	ath occurred at the investigation, in m	e time, date ny opinion, d	and place, death occurr	and due to the ca ed at the time, da	use(s) and mai te and place, a	nner as state and due to th	ed. e cause(s)
To the	Idmox	Me	29b. Signature and title of certifier		V		29c. Lic	ense numbe	er e	29	d. Date signed	(Month, Da	y, Year)
- > -			Juden	11/	11	WILL	NA	36	23		sen be	nbe	76 200T
J				completed car	bee of death	(trem 23a) (Typ	o, Print)	drei	Lla	enson	Rel	Lle	zartowa
- Do	Sta		31. Date filed (Month, Pay, Year) SEP 3 0	2005	Registrar's S	ignature						h	1 2174
. ne	gistr	41		2007	Sealing.	e St.	Grand .					- T Y	

Physicia	an	Decedent's Name (First, Middle, Last) KENNETH SPITZE	?		2. Date of Death Month	Day Year
/Medic Examin		4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Death	SEPT 4	2005 4:30 A M
LXuiiiii	٠.	12800 ROUSBY HALL ROA	AD.	LUSBY		CALVERT
Funeral Director		5. Social Security Number 235-82-2653 G. Sex 1 1 M M 2 F Usual Residence of Decedent	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, AUG 31	Year) 9. Birthplace (State or Foreig Country) VIRGINIA
how		10a. State 10b. County	10c. City, Town or Le			10d. Inside City Limits
or 28a-f show	Director	MD CALVERT	LUS	SBY		1 ☐ Yes 2 🖄 No
a or 2	급	10e. Street and Number 12800 ROUSBY HALL ROAI)	10f. Zip Code		Og. Citizen of What Country? UNITED STATES
Itams 23a	Funeral	11. Marital Status 12. Was De		20657 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
t of Health and Menial Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28e-1 show or other traumatic event, the Medical Examinar must be multiled at	by Fur	If Yes, C	2 X No Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White, etc. Specify: WHITE
"natural", or		3 ☐ Widowed 4 ☐ Divorced Year or 15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/Industry
ene. than "n	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(Give	e kind of work done during most of work DO NOT use retired)	ing	
Hygien thar th ent, the		12	,	CARPENTER	- (F) - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	COMMERCIAL
and Mental Hygiene. Is marked othar than aumatic event, tha M	To Be	17. Father's Name (First, Middle, Last) BENJAMIN SPITZER		18. Mother's Name	e (First, Middle, N L SNYDER	faiden Sumame)
and Men s marke umatic	۲	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and Number or Run		City or Town, State, Zip Code)
of Health a If itam 27 Is or other tre		JANET SPITZER - WIFE		800 ROUSBY HALL RI		
int: If ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from	n State	matory or other place)		20c. Location - City or Town, State
		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee		CEMETERY SEPT 8 2. Name and Address of Facility D		MARTINSBURG, WV
Departr Imports any inju		Charles M. Bigu	<i>\</i>	. В		AL HOME, P.O. BOX 821, WARTINSBURG WV 25402
		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not en each line.			st, Approximate Interval Between
nysician		Immediate Cause (Final disease or condition resulting in death)	llbladden	Comen		Onset and Death
Medical xaminer		Due to	o (or as a consequence of):			0
	Jer	Sequentially list conditions, if any, leading to immediate cause. First Underlying Cause (Disease or injury	o (or as a consequence of):			- William
und- transit	Examiner	that initiated events				
hysician and- the burial-transit	al Ex	Due to	o (or as a consequence of):			
충립	edical	d				
ite has been signad by the attending phoage 2 should be detached for use as to	Physiclan/Me	in the past 12 months?	gnant at time of death 5[Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
signad b	by	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the cause of death?
been si should	Completed				24a. Was an	
e has age 2	дшо				autopsy	prior to completion of cause of death?
	BeC	25. Was case referred to medical		26. Place of Death		No 1 ☐ Yes 2 ☐ No
this certific	P.		Inpatient 2 ER/Outpatie		me 5-Resider	nce 6 □Other (Specify)
r death. actor: After by the funera	:lon:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	of Injury 10 nth, Day Year) 28b. Time of 10 Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred
death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, st			eet and Number or Rural Route Number,
o aci	ert	4 Homicide Buil	ding, etc. (Specify)		City or Town,	State)
rs after d al Diraci lad in by	O	29a. Certifier 12 Certifying Physicien: To the	ne best of my knowledge, deat basis of examination and/or in nner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
a Funaral Diraci letely fillad in by		(Check only 2 Medicel Examiner: On the one)				
n 24 hou ha Funar bletely fill	Medical C	(Check only 2 Medical Examiner: On the and ma		29c. License number	29	d. Date signed (Month, Day, Year)
within 24 hours after of To the Funaral Diract completely fillad in by	edical	and ma		29c. License number 0 4 3306	29 Q	d. Date signed (Month, Day, Year)
within 24 hours after of To the Funeral Direct completely filled in by	edical	and ma		043306	9	119/05

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** sept. 2005 Irene Santos 22, 5:20 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Home Frostburg 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 74 | Yrs. | Nov 23, 1930 | Puerto Rico 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖫 F 105-24-0342 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, it e Madical Examinar must be natified at MD Allegany Frostburg ¥ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Honeysuckle Lane 21532 USA - Puerto Rico filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ¹¤xyes 2□No SpecifyPuerto Rican Specify: Hispanic Completed by 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist Telephone 8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 Is marked ot Unknown Rodriguez Aurora Alicea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna Turbin daughter 6 Green St., Frostburg, MD 21532 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 29 Cremation 3 Removal from State Silbaugh Crematory Sept 27 05 Uniontown, PA ò permit. Page Department of Important: If any injury or once. 22. Name and Address of Facility Hafer Funeral 1302 National Hwy., LaVale, Signature of Funeral Service Licensee 23a. Part1. Enter the dise use or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYO **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner transit. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t Division of Vital Records, P.O. Box 68760 Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yo

9 Unknown Day Year Month 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **X**No or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 o 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospital 29a, Certifier Kcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 26907 SEPTEMBER 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit S. Sidhu, MD, 925 PBishop Walsh Rd., Cumberland, MD 21502 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

			For State Registrar	ate of Maryland /	Department of He Certificate of De		ntal Hygiene Reg. No	/11/5	31879
			Decedent's Name (First, Middle, Last)			2.	Date of Death	·	3. Time of Death
	Physici /Medio		Donald Eugent			S	pton Ser 1	7 2003	
	Examin	er	4a. Facility Name (If not institution, give street		4b. City, Town, or Lo		4c.	. County of Deat	
	Funeral		Washington County 5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year	f Under 24 Hrs. 8.	Date of Birth (Month, Day, Year)	Washing	hptace (State or Foreign buntry)
	Director		215-42-3234 ^{1×m}	^{2□ F} 60	Yrs. Months Days		+.31,1944		ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Washingto	on	Williamsport				1 ☐ Yes 2 🗷 No
	or 28s	Director	10e. Street and Number		10f. Zip Code		10g. Cit	izen of What Co	untry?
	sath w s 23a	ıral	11117 Kemps Mill R	d . as Decedent Ever in U.S.	13. Was Decedent of Hisp	1795	Yan ar No	USA 14. Race - Ame	
"	ritam ritam	Funeral	1 Never Married 2/7 Married 1	med Forces? □Yes 2 ☑ No	If Yes, specify Cuban,	Mexican, Puerto Rica	an, etc.)	Black, White	
93	72 hours after death with the Maryland natural; or itams 23a or 28a-f show dical Exama at must be multified at	Completed by	— · · · · · · · · · · · · · · · · · · ·	Yes, Give A ear or Dates:	1 ☐ Yes 2 X No	Specify:		Specify:	White
15-(n 72 h "natu edice	lete	15. Decedent's Education (Specify only highest grade com		 Decedent's Usual Occupation (Give kind of work done dur life. DO NOT use retired) 	on ing most of working	16b. K	ind of Business/	industry
72	within	omp	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	aintenance Sup	ervisor	Hum	nan Deve	lonment
멀	al Hyg I otha	BeC	17. Father's Name (First, Middle, Last)			8. Mother's Name (Fi			1200211
Maryland 21215-0036	ould b	To I		vde r			ane Hunt		
Mai	d 2 st th and th sn ?7 is n traun		19a. Informant's Name/Relationship (Type, P		b. Mailing Address (Street and				0.1705
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, it a Medical Examinating the indifficulties ones.		Paula Snyder - Wife 20a. Method of Disposition	20b. Place	1117_Kenps Mi of Disposition (Name of ery, crematory or other place)	11, KC - WI Date	I I amspor	cation - City or	Town, State
ij	Page nent c ant: If ury or		Y Burial 2 ☐ Cremation 3 ☐ Remov	ai from State	lawn Mem. Park	Sept.21,2	005 Will	iamspor	t,Maryland
Baltimore,	ermit. Jepartr nports ny inj		21. Signature of Funeral Service Life ins		OSBOTHE TUNE	Faquity Home,	P.A.		
	00 E 8 0	22	23a. Part 1. Enter the disease, or complication	ns that caused the death. Do	425 S. Conoc			msport,	MD 21795 Approximate
	Physician		shock, or heart failure. List only one cau Immediate Cause (Final	use on each line.	5 care	Orsome			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		محان وال			
	Examiner		Sequentially list conditions, b.						75 yes
	ted	nlne	If any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	→ of):				
Ć,	execuin and ial-trau	Examiner	that initiated events c.	Due to (or as a consequence	a of):				
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	edical	d						
	ertifica ding ph		IF FEMALE:	yes, outcome of pregnancy					
Вох	seath c attend	Physiclan/M	in the past 12 months?	□Live birth 2 □ Fetal deat □Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deli Month	Day Year
P.O.	t the c by the tachec	hysi	9 Unknown	Unknown					
	res tha signed be det	by P	Part II. Other significant conditions contribut	A/1		in Part I.			the cause of death?
ord	w requir been si should	eted	BOLOELINE WIAG	ETES PIE	LLITUS		1 ☐ Yes 2	,	obably 4 Unknown
Rec	nelaw hast ge 2 s	Completed					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
ta	iician: Th certificate rector, pag	Be Co	25. Was case referred to medical			6. Place of Death (C	1 ☐ Yes 2 ☑ No	1 ☐ Yes	2 □ No
<u>_</u>	Physicia this cer al direct	To B	examiner? 1 Yes 2 No Hospit	al: 1 Inpatient 22 ER/C	Othor	4 ☐ Nursing Home		6 □Other (Spec	cify)
o u	ding Physician: The h. After this certificate h funeral director, page		Natural 5 ☐ Pending		Time of 28c. Injury at 1njury Work?		Describe how injur	y occurred	
Division of Vital Records,	Attand death ctor: A y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, f		s 2 □No 28f.	Location (Street an	d Number or Ru	ral Route Number,
<u>S</u>	safter safter safter al Dire	Certification;	4 Homicide	building, etc. (Specify)	•		City or Town, State)	
	To the Hospital or Attanding Physician: The law requires that the death certil within 24 hours after death. To tha Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical ((Check only Medicel Examiner: C	on the basis of examination a	ge, death occurred at the time, and/or investigation, in my opin	date and place, and ion, death occurred a	due to the cause(s) t the time, date and	and manner as place, and due	stated. to the cause(s)
	o the ithin 2 o tha omple	Med	29b. Signature and title of certifier	nd manner stated.	29c. License n	umber	29d. Dat	te signed (Month	n, Day, Year)
<u>.</u>	1		> SMO Doent	Madina C.	com 000	56965	Sen	A 18	2005
	2		30. Name and address of person who completed the Stephen T. Kote	1 7.	(Type, Print)	3	et Hai	HIST am	n ma
	Sta Registr		31. Date filed (Month, Bay, Year) SEP 2 0 2005	322Registrar's Signature	houle		,)	
			JEF & U ZUUJ	MERCUN N'	10/10				

State of Maryland / Department of Health and Mental Hygien \(\hat{\omega} \) \(\hat{\omega} \)

3		8	8	0
-	- 6	~	\sim	$\mathbf{}$

			1 - State Registrar			Ce	rtificate	of L	Death			Reg. No.	000	31000
	01		1. Decedent's Name (First, Midd	le, Last)							2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		M	ARY ALIC	CE SHA	W	,				SEPT.	12,		3:03 P M
	Examir		4a. Fecility Name (If not institution	n, give street and t	n <i>umber</i>)		4b. City, To	own, or	Location of	Death		4c.	County of Deet	h
b			7603 CHARLTO	N AVE.					N HEI				RINCE G	EORGES
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖫 F		yrs. last birthday)	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of B (Month, L	irth Dey, Year)	Co	hplace (Stete or Foreign untry)
	Director		298-09-1042		8	9 Yrs.	ll_				JULY	5,191	6	ОНІО
	and and		Usual Residence of Decedent 10a. State 10b. County	y	10c.	. City, Town or Lo	ocation							10d. Inside City Limits
	Aaryl F sho	ō	MD DDTNG	E CEODCEC			BERWYI	a 1117	тепте					1 X Yes 2 □ No
	288-	Director	MD. PRINC	E GEORGES			10f. Zip C		TGHIS	•	_	10g. Citi	zen of What Co	untry?
	with a or	ā		TTON AVE			702.0		740					
	leath	era	7603 CHAR		ecedent Ever i	in U.S. 13.	Was Decede			in? (Spec	cify Yes or N	10-	U.S.A. 14. Race - Ame	
_	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural, or Items 23a or 28a-f show other than "natural, or Items 21a or 28a-f show event, Ite Medical Exam are must be traillist at	Funerai	1 ☐ Never Married 2 ☐ Mar	Armed	Forces? s 2 No		If Yes, specif	y Cubar	, Mexican,	Puerto P	Rican, etc.)		Black, White	etc.
Š	urs a	Ď	3 ☐ Widowed 4 🏋 Divorce	if Yes.	Give Tales:		1 ☐ Yes 2	No	Specify:				Specify: WH	ITE
5	2 ho	ted		nt's Education	٠	16a. Dece	dent's Usual	Occupa	tion	- f	_	16b. Ki	nd of Business/	
7	nn 7	ompieted	Elementary/Secondary (0-12)	est grade complete College	e (1-4or 5+)	life.	DO NOT use	retired)	uring most	OF WORKIN	g			
7	giene giene r th	Соп		2			BOOKKI	EEPE	R				OFFICE	
3	al Hy loth	Be (17. Father's Name (First, Middle	, Last)					18. Mother	's Name	(First, Middl	le, Maiden	Sumame)	
2	should bind Menti	၉	WILBERT	HENRY E	BORCHER	S				GE	ORGIA	M.	STOKE	S
9	2 sho and I is ma		19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Street a	n <i>d Numbei</i>	r or Rural	Route Num	ber, City o	r Town, State, 2	lip Code)
<u>,</u>	and and a salth n 27 i		GEORGIA SHAW	PLOPA/DAU	JGHTER	7603	CHARI	LTON	AVE.	, BE	RWYN	HEIGH	TS, MD.	20740
ב	T S T T T		20a. Method of Disposition	3 Domewal fra		 Place of Disposer cemetery, creater 	osition (Name matory or oth	of er place)	Da	ate	20c. Lo	cation - City or	Fown, State
Ĕ	Pages nent of ant: if it		1 ☐ Burial 2 🛣 Cremation `4 ☐ Donation 5 ☐ Other (;	Specify)	m State	CHAMBER	RS CRE	OTAN	RY 9	-15-	2005	RI	VERDALE	, MD.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural, or items 23a or 28a-f show amy injury or other traumatic event, it a Medical Exprised must be notified at once.		21. Signature of Funeral Service	Licênsee	1611)	CF CF	2. Name and	Address	of Facility	ном	IF & C	REMAT	ORIUM, P	.Α
			23a Part 1 Enter the disease of	or complications the		00091 58							, MD. 2	0/3/ Approximate
			23a. Part1. Enter the disease, o shock, or heart failure. Lis											Interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	-		derot	ic C	Arc	100 V	45 CE	las 1	7 4	T Dise	are
	Examiner		,	Due	to (or as a con	sequence of):								
		-	Sequentially list conditions,	b	to (or as a con	sequence of):		<u></u>			· · · · · · ·			
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	(0.00									
	ertificate be executed Jing physician and e as the burial-transit	Examine	that initiated events resulting in death) Last	c. Due	to (or as a con	sequence of):								
oo'	be e siciar buris													
000	phys phys s the	edical		d										
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	₹	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of pre	egnancy							23d. Date of deli	verv
	atter for a	Physician	in the past 12 months?	1 1 1	e birth 2 □ F egnant at time	retal death 3L	□Ectopic prec □ Other (spec						Month	Day Year
	lhe d y the	ıysi	9 Unknown	9□ Uni										
L	Ihat led b		Part II. Other significant condit	ions contributing to	death but not	resulting in the u	nderlying cau	se give	n in Part I.		23e. Did	tobacco u	se contribute to	the cause of death?
3	uires n sigr ld be	d by									1 🗆	Yes 2	□No 3□Pro	obably 4 Dunknown
cords,	w req	lete									24a. Wa	s an	24h Were au	topsy findings available
ב	sician: The law s certificate has b lirector, page 2 s	Completed									auto	opsy formed?	prior to death?	completion of cause of
ē	n: The icate har, r, page										1 Yes	2 No	1 Tes	2 No
2	ysician: is certific director,	Be	25. Was case referred to medica examiner?	Hospital				Othe	e-		(Check only			
5	Phys this ral dii	10	1 ✓ Yes 2 □ No 27. Manner of Death	11	☐ Inpatient : te of Injury	2 ER/Outpatier 28b. Time o		c. Injury	4 U Nur		8d. Describe		Other (Spec	ify)
5	ding F h. After funer	lon	1 ☐Natural 5 ☐ Pendi	ing (M	onth, Day Yee	r) Injury	м 200	Work'	? es 2 □ N		00001100	, now injury	y occurred	
JIVISION	death death stor:	cal	3 Suicide 6 Could		ce of Injuny - A	At home, farm, st					8f Location	(Street and	d Number or Bu	ral Route Number,
2	or A after Direction by	Certification:	4 ☐ Homicide determ		ilding, etc. (Sp		eet, factory,	DITICO				own, State,		ar roote worder,
٠,	pital ours a	Ö	29a. Certifier 1 ☐ Certifyi	ing Physician: To	the hest of my	knowledge deat	h occurred at	the time	e date and	I niace a	nd due to the	e cauce(e)	and manner as	etated
	Hos 24 hc Fun stely	dical	(Chack only 3 - deading	I Everninger On the	basis of ovan	nination and/or in	voction i		inion donti	honourro	d at the time	data and	place and due	to the equac(a)
	To the Hospital or Attending Physician: The law requires that the death o within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attence completely filled in by the funeral director, page 2 should be delached for us	Me	29b. Signature and title of certific	er			29c.	License	number			29d. Date	e signed (Month	i, Dey, Year)
			12-	lu B.	Last	2 90	1	Kho	553	92	7	Sen	tell	14,2005
	5		30. Name and address of person	who completed or	ause of death ((Item 23a) /Tuna	Print	, , , ,		•				
			SALVA CA	S,/ws	Ten 30	50/ /do	spita	13	Vive	? (Lev	erle	rin	s loud
	Sta	ite	31. Date filed (Month, Day, Year) 32	Registrar's S	ignature /	0.000	, -				1		/
	Registi		29b. Signature and title of certification of person series of person series (Month, Day, Year SEP 11)	5 2005	e gira	15 190	Notice of the second							

			For State Registrar	State of Ma	aryland		artment <i>tificate</i>					giene	95	31881
ı	Physici	an	Decedent's Name (First, Middle, Last) Wilburn		ipton	1					2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give		трсоп		4h City 1	Town or	Location of		Septemb	er 15,	2005	8:30 A [™]
	Examin	er	1595 Thomas Court	street wie namber,					Rock				deric	k
	Funeral		5. Social Security Number 6. Sex		e (In yrs. la	st birthday)	If Under	1 Year	If Under		8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
Ш	Director		414-34-9123 X]M 2□F	86	Yrs.	Months	Days	Hours		Feb. 16	, 1919	Tenn	essee
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							I Od. Inside City Limits
	Maryli feho	ŏ	Maryland Frederic	1.		Point		ocks						1√2Yes 2 No
	28a-	rect	10e. Street and Number	·K		TOTHE	10f. Zip					10g. Citizen of	What Cou	ntry?
	h with	Funeral Director	1595 Thomas Court					217	777			United	Stat	es
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. \	Vas Decede	ent of His	spanic Orig	gin? (Spec	cify Yes or No-		ce - Americ	can Indian,
36	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow he Medical Examiher must be notified at	by Fu	1 Never Married 2 Married	1 XYes 2 1	™Wor1	.d	□ Yes 2		Specify:		,	Specif		White
Ö	hour furel'	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	War I	16a. Deced	lent's Usual	I Occupa	ition			16b. Kind of B	lusiness/In	dustry
15	n "na Nedic	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5		(Ĝive life. l	kind of worl OO NOT use	k doné d e retired)	uring mosi	t of workin	g			
21215-0036	d with	Completed	Libriditaly/3600fidaly (0-12)	2	,*,	Ste	elwor	ker				Stee1	Indus	try
lud	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden Sumar	ne)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "naturel; or items 23e or 28a-f ehow amy injury or other treumatic event, the Medical Examinat must be notified at once.	မှ	Hugh Tipton 19a. Informant's Name/Relationship (Ty,	no Print)		10h Mailin	a Addross	(Street a				r, City or Town	State 7in	Code
Ma	id 2 s ith an 27 is i			•	. 20							Rocks		
ē,	s 1 and 1 Healthean 1 tem 2	lt j	<u>Diane Kirkpatrick</u> 20a. Method of Disposition	/ Daugnie	20b. Pla	ace of Dispo	sition (Nam	e of	1			20c. Location		
altimore,	Pages ent of nt: If i		1 Murial 2 Cremation 3 R 1 Donation 5 Other (Specify)	emoval from State		. Oliv				9/19/	2005	Freder	ick,	Maryland
	permit. DepartmImporte any inju		21. Signature of Funeral Service License	96	,							Funeral		
<u> </u>	9 G E E G	Si 1	1 ourmey to	ruffer								ınswick	, MD	21716
U			23a Part. Enter the disease, or compli shock, or heart failure. List only or	e cause on each lir	10.				7 3	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
ď	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	metasto		nms	mall	cel	llu	mg	can	er		2 years
	Examiner			Due to (or as	a conseque	ence of):								
	M S ED	Jer	Sequentially list conditions, It any leading to immediate	Due to [or as	a consque	ence of								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
20,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as	a conseque	ence of):								
68760	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dlcal	d											
ŏ	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23d. Da	te of delive	ery
m	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Other (spe					Мо	onth	Day Year
<u>Ч</u> О	at the by th	hys	9 🗆 Unknown	9Ll Unknown										
S S	res that the de signed by the a be detached f	by	Part II. Other significant conditions con	tributing to death b	ut not result	ting in the ur	iderlying ca	iuse give	n in Part I.		N.4	bacco use cont es 2□No		ne cause of death? ably 4 □Unknown
Ö	w require been si should?	eted									V 8000			
Records,	The law ate has page 2	Completed									24a. Was a autops perform	ned?	prior to cor death?	psy findings available inpletion of cause of
		0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only on		1 🗌 Yes	2 No
<u>=</u>	yelcien: is certific director,	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 🗌 Inpatie	nt 2□E	R/Outpatien	3 □ DO	Othe		rsing Hom			er (Specify	1)
n of	Attending Phyelcien: r death. ector: After this certifics by the funeral director, i		27. Manner of Death 1 Satural 5 Pending	28a. Date of Injui (Month, Day	y Year) 2	28b. Time of Injury	28	Bc. Injury Work	at ?	28	d. Describe ho	w injury occur	red	
SIO	uttendi death. ctor; A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		441		М		es 2□ñ		N. 1 100			
	after death after death Director; in by the	Certification;	4 Homicide determined	28e. Place of Injuding, etc		10, tarm, stre	et, factory,	Office		28	City or Town	n, State)	er or Hura	I Route Number,
	spite		29a. Certifier 1 Certifying Phys	ician: To the best	of my know	ledge, death	occurred a	t the time	e, date and	d place, an	nd due to the ca	ause(s) and ma	anner as st	ated.
	To the Hospitel or A within 24 hours after To the Funeral Director Completely filled in by	edical	(Check only 2 Medical Examir one)	er: On the basis of and manner sta	examination ted.	on and/or inv	estigation,	in my opi	inion, deat	th occurred	d at the time, d	ate and place,	and due to	the cause(s)
	To with To t	Σ	29b. Signature and title of tertifier	MA	\cap		29c.	License	number	14	2	9d. Date signe	d (Month,	Day, Year)
	. 1110		11/	W.	リ		1	, -	010	1		111) (3	7
5	DAININ	8	Florence F.	mpleted cause of d 5 Kand	-	111	^{rnnt)} 50	of L	N	715	Street	- Frede	urick,	MD 21701
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	s Signatu	ire مع	1				-			
	Registr	ar	SEP 13	בטעט 🍆	1 Sec	, st	1900							

			1 - For State Registrar	State of Mar	yland /		rtment of H		nd Men		iene g. No.	005	31882	
	Dhysisi		1. Decedent's Name (First, Middle, La	ist)				-		Date of Deatl Month	h Day	Year	3, Time of Death	
	Physicia /Medic		Sarah	Та.у	lor					ept.	13	200		
	Examin		4a. Facility Name (If not institution, gir	re street and number)			4b. City, Town, or			-		ounty of Deat		
			3706 Vega Rd	7 400	Taura lant h		Randall If Under 1 Year			Date of Birth	Ba	ltimo		
	Funeral Director			Sex 7. Age (1 □ M 2 X F 7.1	'In yrs. last bi	Yrs.	Months Days	Hours	Min.	Month, Day,	Year)	Co	hplace (State or Foreign juntry) arfield F	
			Usual Residence of Decedent							<u>'L </u>	193	4 CIE	arriero F	Α
	72 hours after death with the Maryland natural; or Hems 23e or 28e-f show Itsal Examare metimust be twiffled at		10a. State 10b. County	1	Oc. City, Tov	wn or Loc	ation						10d. Inside City Limits	
	a-f st	ţō	Maryland Balt	imore	Rand	lall	stown						1 GYes 2 □ No	
	or 28,	lrec	10e. Street and Number				10f. Zip Code			10	0g. Citize	n of What Co	ountry?	
	23e c	a	3706 Vega Rd				211	33				USA		
	ems	iner	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- in, etc.)	14	. Race - Ame Black, Whit		
36	or it	by Funeral Director	1 Never Married 2 Married	1 Tyes 2 □ No If Yes, Give			☐ Yes 2☑ No	Specify:			S	pecify:		
8	ural',	d b	3 ☐ Widowed 4 ☑ Divorced	Year or Dates: 5	<u>2-53 </u>	. 0		-41			105 16-4	Bla	ck	_
21215-0036	"nat	Completed	15. Decedent's E (Specify only highest gi	ade completed)	168	(Give k	ent's Usual Occupa ind of work done o O NOT use retired	durina most c	of working		160. Kind	of Business/	industry	
12	within ene. than "	mc	Elementary/Secondary (0-12)	College (1-4or 5+) 4 +			reacher	•		Г)0377°	v Inc	titute	
d 2	Hygi Hygi thar int, I		17. Father's Name (First, Middle, Las						's Name (Fi	rst, Middle, N			cicace	
Maryland	should be ind Mental a markad o	To Be	Roy	Hansar	đ	S	r.	Amy	7			Pittm	an	
37	s 1 and 2 should if Health and Men item 27 la marka other traumatic	-	19a. Informant's Name/Relationship				Address (Street			oute Number,				
	S = 6		David Taylor /	Son	2	408	Boones	Ln F	ores	tvill	e M	D 209	47	11
Baltimore,	es 1 and of Health item 27 r other t		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other plac		Date			tion - City or		
Ë	permit. Pages Department of I Importent: If ite any injury or of		1 Burial 2 □ Cremation 3 Companies 1 Cremation 3 Companies 2 □ Cremation 3 □ Other (Spec		l	-	-		/21/	05 C	hel	tenha	m,Marylan	d
alti	mit. partir corte vinju		21. Signature of Juneral Service Lice	ensee \(\text{\tinc{\text{\tin}\text{\tinit}\\ \text{\tin}}\\ \tint{\text{\text{\text{\text{\text{\text{\text{\text{\ti}\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\text{\text{\text{\texi}\text{\texi}\text{\texi	-		Name and Address						,,	
m	permi Depa Impo any ir		Xloyd	M. Colex	191	Ada	ams Fun	eral	Home	PA, Ag	uas	co MD	20608	Ja
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the	ne death. Do	not ente	r the mode of dyin	g, such as ca	ardiac or re	spiratory arre	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	CVA									Onset and Death	
	/Medical		resulting in death)	Due to (or as a	consequence	e of):								
	Examiner		Sequentially list conditions, if any, leading to immediate	b										_
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e ot):								
	eecute and I-tran	хаг	that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit					·								
687	licate I physics the b	hysiclan/Medical		d										
Вох	eath certific attending p I for use as t	/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23	d. Date of del	ivery	
ĕ	death a atte	clai	in the past 12 months? 1 ☐ Yes 2 🛣 No	1□Live birth 2 4□Pregnant at tir			Ectopic pregnancy Other (specify)					Month	Day Year	
O.	that the de ted by the a detached	nysi	9 Unknown	9□ Unknown	171									
٠, ص	law requires lhat the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death but	not resulting	in the un	derlying cause give	en in Part I.	- 1	23e. Did tob	acco use	contribute to	the cause of death?	
ρğ	w require been sig should b		hypertensic	<u>n</u>						1 □ Ye	s 2 X	No 3□Pr	obably 4 Unknown	
00	aw re as bee 2 sho	ompleted	٦,							24a. Was ar		24b. Were at	atopsy findings available completion of cause of	,
Vital Records,	9 4 9	E O				_				autops: perform	ned?	death?	Le.	
ta	an: Th rtificate tor, pag	Se C	25. Was case referred to medical					26. Place o	of Death (C	hack only on	-			
\	Physician: this certific ral director,	O B	examiner? 1 Yes 2	Hospital: 1 Inpatient	2 ER/C	Dutpatient	3□ DOA Oth	er: 4 🗌 Nurs	sing Home	5 X Reside	nce 6[Other (Spe	cify)	
υot	ding Ph h. After th funeral	ä	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b.	. Time of Injury	28c. Injun Wor	y at k?	28d.	Describe ho	w injury	occurred		
<u>S</u>	at at	atle	2 Accident investigati					Yes 2□N						
Division	or Att after de Diract in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, i (Specify)	farm, stre	et, factory, office		28f.	Location (Sti City or Town		Number or Ru	ural Route Number,	
Ω	urs af													-
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier 1 Certifying F (Check only 2 Medical Example)	hysician: To the best of iminer: On the basis of e and manner state	xamination a	ge, death and/or inv	estigation, in my o	ne, date and pinion, death	n occurred a	it the time, da	iuse(s) ai ate and p	lace, and due	to the cause(s)	
	o tha ithin o the omple	Med	29b. Signature and title of certifier	and married state			29c. Licens	e number		29	9d. Date	signed (Mont	h, Day, Year)	
	⊢≯⊢ŏ			ama			Doos	1020	8		9/1	5/00	5	
			30. Name and address of person who		ath (Item 23a	ı) (Type, F					. , ,	1		_
	NB Insi		June Brains	WW 120	5 40	rle f	Ed Ct1 3	20 /	wth	ervi U	e v	nd :	21093	
Í	Sta	ite	31. Date filed (Month, Day, Year) SEP 1 6		's Signature	6	had.							
34	Regist	rar	SEL T 0	TOUS TOUR	W 10	//	E CONTRACT							

	-		1 - For State Registrar Amended 26,	State of Ma 9/16/05, I						giene Reg. No. 2005	31883
			Decedent's Name (First, Middle, Last,						2. Date of Dea	ath	3. Time of Death
4	Physici /Medi		Elvin Dail Tho	omas					SEPTEM!	Day Year BER 13, 2009	- 1002 AM
V	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation of Death		4c. County of Dea	ath
				ENERAL	HOSPIT	TAL CA	1413	RIDGE If Under 24 Hrs.	- 100	DORCH	ESTER
	Funeral Director		5. Social Security Number 6. Sec. 218-16-8114	x 7. Ago 1. M 2 ☐ F	e (In yrs. last birt 81	Yrs. Months	Days	Hours Min.	8. Date of Birt (Month, Date Aug • 2	1, 1924 Ma	rthplace (State or Foreign Country) Tyland
			Usual Residence of Decedent		01				Aug. 2	1, 1724 Ha	Lytand
	nyland how		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
\Diamond	e Ma	cto	Maryland Dorcheste	er.		Cambri					1 ☐ Yes 2 ☐ Mo
4	with the Maryland a or 28e-f show	Dire	10e. Street and Number			10f. Zip		1.2		10g. Citizen of What C	-
3	s 23s	Funeral Director	3305 Ocean Gatewa	1y 12. Was Decedent I	Ever in H.S.	13 Was Decer	216:		acity Vas or No.	USA - 14. Race - Am	
0	72 hours after death natural', or Items 23 Josef Erie: de recesal	F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?					pecify Yes or No- Rican, etc.)	Black, Wh	
036	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 No	Specify:		Specify: W	hite
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a.	Decedent's Usua (Give kind of worlife. DO NOT us	I Occupati k done dui	on ring most of worl	king	16b. Kind of Business	s/Industry
121	within ene. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5	Di	rector (e retired) of Pul	blic Wor	·ks	County Go	vernment
	filed v Hygie other t		17. Father's Name (First, Middle, Last)							Maiden Sumame)	VELTIMETTE
and	nould be f d Mental b narked of natic ever	To Be	Medford Thomas								
Maryland	shoul nd Me mark imati	F	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b.	Mailing Address	(Street and		leen Da	ar, City or Town, State,	Zip Code)
	and 2 salth a n 27 is		E. Dail Thomas, II	/Son	7	61 Glene	ea les	s Dr., E	ort Was	hin ton, M	D 20744
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic event, the Meulcal Euroria at mant by notlined at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Iomoval from State	20b. Place of cemeter	Disposition (Nan y, crematory or o	ne of ther place)		Date	20c. Location - City of	r Town, State
<u>m</u>	Pag ment ent: It ury o		'4 □ Donation 5 □ Other (Specify)		Dorche	ster Men		. 09/1	6/2005	Cambridge.	MD
Salt	permit. Departr Importe any injection		21. Signatore of Funeral Sarvice Licens	ee , £		22. Name an	d Address	of Facility	meral H	ome, P.A. MD 21613	
	905 g a		Galler Tari	et- /y	never	(308 Hi	gh St	t., Camb	ridge,	MD 21613	Annaumata
	Priysician /Medical Examiner		23a. Rart Enter the disease or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Arter		otic Ho					Approximate Interval Between Onset and Death
L		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	of):					
	cate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	s							
90	e exe	Ä	resulting in death) Last	Due to (or as	a consequence of	of):					
8760,	cate b	dicai		d							
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pro				23d. Date of de Month	elivery Day Year
Ω.	res that the signed by t be detach		Part II. Dther significant conditions con	ntributing to death bu	ut not resulting in	the underlying ca	ause given	in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	quires n sign	Completed by	Chronic obstruct	ive Pul	nonay	d-seo	be		1 7	es 2□No 3□P	robably 4 Unknown
00	s been si	ojete			,				24a. Was a		utopsy findings available
Re	The la	E O		-					autop perfor 1 Yes	med? death?	completion of cause of s 2□ No
ital	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?				2	6. Place of Deal	h (Check only or		
<u>></u>	Physic this ce al dire	5	1 ☐ Yes 2 ☐ No	lospital:	THE RESERVE OF THE PARTY OF THE		_	4 Nursing H		ence 6 Other (Spe	ecify)
Division of Vital Records,	ding P h. After t funera	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	y 28b. T <i>Year)</i> Ir	ime of 2 njury M	8c. Injury a Work? 1 □ Ye	t s 2 🗆 No	28d. Describe h	ow injury occurred	
visi	Attendi er death. ector: A by the fu	tifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, fai	rm, street, factory	, office		28f. Location (S City or Tow	itreet and Number or R	lural Route Number,
Ö	itel or irs after rel Dii										
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical			examination and					ause(s) and manner a date and place, and du	
	To the Mithin To the	Me	29b. Signature and title of certifier	12 × 1		29c	. License n	umber	2	29d. Date signed (Mon	th, Day, Year)
			1 seell	The Paris		j) 47	7924		9-14-0	5
			30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type, Print)	, ,	,	1.0		
				TWWY	300 /	AUROR,	4 5	CAM	185R 1100	al MD	21613
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN TITANNY BUD AURURA ST CAMBRIDGE MD 2/6/1 State Registrar 31. Date filed (Month, Day Year) 1 6 2005 1 6 2005 1 6 2005 1 6 2005											

Hilario Castil	lo Valdez Please 1	ype or Print in Black Indelible Ink. En	•	•
05-6241 AKG	1 - For State Registrar	State of Maryland / Department of Healt Certificate of Dea	th	4000 31884
Dhysisian	Decedent's Name (First, Middle, Last,	7	2. Date of Death	3. Time of Death
Physician /Medical	H1/	treet and number) 4b. City, Town, or Locat	1002 Septemb	er 11,2005 5:24 P M
Examiner	4a. Facility Name (If not institution, give Washington Advent			ontgomery
Funeral Director	5. Social Security Number 6. Se 579-25-9041	M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hou	ors Min. 8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country), Sich Kep
Maryland -f ehow	10a. State 10b. County	P. George HVAMSVII	le	10d. Inside City Limits 1 ☐ Yes 277 No
uth with the Mar 23a or 28e-f el ust be notified	10e. Street and Number 503 CH	Wy Rd 103 101. Zip Code 20	782 0	MINICAN REP
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Item 27 le marked other then "natural", or items 23a or 28e-f ehow other treumatic event. Ite Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forcas? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex Yes 2 □ No Spe		14. Race - American Indian Black, White, etc.
Maryland 21215-0036 to 2 should be filed within 72 hours aft that Medical Hygiene. 27 is marked other than "natural", or treumatic event, the Medical Exercitive materials.	15. Decedent's Edu (Specify only highest grad	cation 16a. Decedent's Usual Occupation (Give kind of work done during)	most of working	Kind of Business/Industry
vithin vithin then the Max	Elementary/Secondary (0-12)	College (1-4or 5+)	gring H	oeticulture
be filed that Hygin of other event.	17. Father's Name (First, Middle, Last)	1/a/a/a 18. M	ther's Name First, Middle, Maid	The state of the s
laryland 212's should be filed within and Mental Hygiene. In marked other then sumatic event, the Mental To Be Comp	19a, Informant's Name/Relationship (T)	De, Print) 19b. Mailing Address (Street and Nu	TIIIA	AST7//U
e, Ma 1 and 2 s Health an em 27 leu	ANA CAST	110-SISTER 4035 64	- PLACE W	DC 20017
O 2°= 5	20a. Method of Disposition (Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State 20b. Place of Disposition (Name of cometery, crematory or other place) EMENTERIO TUNC	9/24/05 FZ	Location - City or Town, State
Baltim permit. Pag Depertment Important: eny holury o	21. Signature a Funeral Service Licens	22. Name and Address of F	acility STELLING	FINERAL SErvice
2 412 64	23a. Part1. Enter the disease, or comp	cations that caused the death. Do not enter the mode of dying, such the cause on each line.	n as cardiac or respiratory arrest,	Approximate
Physician	Immediate Cause (Final disease or condition	Haugin a		Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to (oras) consequence of):		
D = C	Sequentially list conditions, if any, backing to fam. distinct cause. Enter Underlying Cause (Disease or injury	Dua to (or as a nonsequence of):		
60, be executed clen and burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		
Box 68760, sath certificate be ex ettending physiclen for use es the burial for use cathe burial cian/Medical Excian/Medical Ex				
× 687(entificate I ding physise es the I	IF FEMALE:	3c. If yes, outcome of pregnancy		
P.O. Box 68766 Thet the death certificate be ad by the eltending physicit detached for use es the bu Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions co	stributing to death but not resulting in the underlying cause given in P		o use contribute to the cause of death? 2/2/3/No 3 Probably 4 Unknown
Division of Vital Records, to attending Physician: The law requires tater death. Director: Aller this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	3		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			performed?	danta?
of Vita hysiclen his certiff I director To Be	25. Was case referred to medical examiner? 1 XYes 2 No	osnital: 3737 Other	Place of Death Check only one	6 ☐ Other (Specify)
On of ding Phys. h. Alter this funeral di		28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury at Work?	28d. Describe how in	
Division of Vital tall or Attending Physicien: is after death. el Director: Alter this certification by the funeral director. I	2 Accident investigation 3 Suicide 6 Could not be determined	9-11-05 16:27 M 1 ☐ Yes 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f Location /Street	and Number or Rural Route Number.
Div		building, etc. (Specify)	#10Z HVA	503 Chillum Pol
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami	sician: To the best of my knowledge, death occurred at the time, dat ner: On the basis of examination and/or investigation, in my opinion, and manner stated.	e and place, and due to the cause death occurred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the Hospital within 24 hours a within 24 hours a To the Funeral I completely filled	29b. Signature and title of contifier	29c. License numt O.C.M.E		Date signed (Month, Day, Year) otember 12, 2005
CK3)	30. Name and address of person who co	mplet u of death (Item 23a) (Type, Print) 111 Penn Street,	Baltimore, Maryl	and 21201
State Registrar	31. Date filed (Month, Day, Year) SEP 1, 6 2005	2. Registrar's Signature		

		1 - State Registra America Ite 1. Decedent's Name (First, Middle	n #18&19a&l	Maryland / b Per In						2. Date o	Reg	200)5	3 885
Physici /Medi		BANDANA				VOH	RA			Month 09		15	Year 05	3:27 P
Examir		4a. Facility Name (If not institution	•	er)		4b. City, Tow			of Death				y of Death	
Funeral		SHADY GROVE H 5. Social Security Number		Age (In yrs. last i	birthday)	ROCKV	ear	If Under		8. Date o	f Birth	MONTG		lace (State or Forei
Director		217-06-0115	1□M 2 ∏ F	58	Yrs.	Months Da	ays	Hours	Min.	MAY	25,	1947	PAK	ISTAN
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							1	0d. Inside City Limi
Mary a-f sho	tor	MD MONT	GOMERY	GAIT	HERS	BURG								1 X Yes 2 □ N
or 284	Director	10e. Street and Number				10f. Zip Coo	de				10	g. Citizen of	What Cour	ntry?
sath w		422 CAROUSEL	CT .	at Ever in II C	10.1) 877		-:-0./0	-: V		INDIA		an India
72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Marri 3 □ Widowed 4 □ Divorced	Armed Force	as? □ X No	'	Was Decedent f Yes, specify (1 ☐ Yes 2 ☐	Cuban,	Mexican Specify:	gin? (Spe n, Puerto I	Rican, etc.)	Bla	ce - Americ ck, White, fy ASIA	
72 hor	eted	15. Decedent (Specify only highes	's Education t grade completed)	16	(Give	dent's Usual Ockind of work do	one dur		t of workir	ng	16	6b. Kind of E	Business/In	dustry
within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT use re EMAKER	etired)	Ů				OWN H	OME	
be filed tal Hygie d other	Be C	17. Father's Name (First, Middle,	_ast)				1:	8. Mothe	r's Name	(First, Mic	ddle, Ma	aiden Suma	me)	-
and Mental and Mental s marked o umatic eve	70	SATYA DEV DIWA		_						YERI				
d 2 sh th and th sn traun		JIM Deep VOH	RA - SON	1:	4	ng Address (Str	ahai	r						
f Heal		20a. Method of Disposition		como	of Dispo	01. CAEA sition (Name o natory or other	f	DR.		ate		C. Location		
end and and and and and and and and and a		1 ☐ Burial 2 ★Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from Sta pecify)	110	-	VA CRE		ORY	09-	16-05		ARLING	STON.	VA
permit. Pages 1 and 2 should by Department of Health and Ments Important: If itam 27 is marked any injury or other traumatic or once.		21. Signature of Funeral Service	iognsee			Name and Ad 901 N.					N F	UNERAI	HOM	3
2		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that causonly one cause on each	sed the death. Dh line.										Approximate Interval Between Onset and Death
nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	AC ARRES										Onset and Death
xaminer		Tooling in county		VENTRICI		DAGEIM	OTT A	OM						
MAN	Jer	Sequentially list conditions, it any, leading to himmediate cause. Enter Underlying Cause (Disease or injury		as a consequence		DISCU	CIT	UN						
transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	с.											
physician and the burial-transit		rosaking in doaling East	Due to (or	as a consequenc	e of):									
g phys as the	edical	-	d									1		
e attending physician and od for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnancy n 2 D Fetal dea	th 3	Ectopic pregna	ancy						te of delive	•
y the at	ysicl	in the past 12 months? 1 ☐ Yes 2 [X]No 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of death n		Other (specify						M	onth	Day Year
ned by the detached		Part II. Other significant condition	ns contributing to deat	h but not resulting	g in the ur	nderlying cause	gıven	in Part I.		23e. E	oid toba	cco use con	tribute to th	e cause of death?
been sign	ed by			<u> </u>						1	☐ Yes	2XXNo	3 Prob	ably 4 Unknow
2 S	ompleted				_						Vas an utopsy	24b.	Were autop	osy findings availab
cate h	Con									1 🗆 Ye	erforme	d? No	death?	2 X No
certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:				2 Other:			Check or				
er this certific eral director,	-	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of I	njury 28b	. Time of	28c. l	njury al	4 🔲 1401				e 6 □Oth	_)
r death. actor: After by the funera	atlo	1 X Natural 5 Pending 2 Accident investig	ation	Day Year)	Injury		Work? 1 ☐ Ye:	s 2 🗆 N	No					
Dir.	ertification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At home, , etc. <i>(Specily)</i>	farm, str	eet, factory, offi	ice		2	8f. Location City or	n (Stre Town, S	et and Numi State)	ber or Rura	Route Number,
4 hours Funaral ely filled	edical C	29a. Certifier (Check only one) 1	g Physicien: To the be exeminer: On the basis	s of examination a	ge, death and/or inv	occurred at the	e time, ny opin	date and	d place, a	nd due to	the caus	se(s) and mage and place,	anner as st and due to	ated. the cause(s)
within 24 h To tha Fur completely	Me	29b. Signature and title of certifier	()			29c. Lic	ense n	ıumber			29d	. Date signe	d (Month, I	Day, Year)
9		· ()(00	Yan			60)548	3			0	91520	05	
•		30. Name and address of person				Print)								
-04		THOMAS ODAR 15 31. Date filed (Month, Day, Year)	225 SHADY (GROVE RD	. #2	O1 ROCK	CVII	LE,	MD 2	0850				
Sta Registi			2005	istrar's Signature	600	ALC)								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 5:45 am ^M JOHN WHITAKER Sept 12 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Thomas More Nursing and Rehab. Hvattsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**x**M 2□ F 51 North Carolina Director 579-70-8582 Feb. 14, 1954 Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Director MD Prince George's Lanham 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 9417 Fontana Drive 20706 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after Amed Folces! 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced B1ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 10th College (1-4or 5+) Custodian Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other traumatic event QMCs. 17 Father's Name (First Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be Charlie Whitaker Sr. Mattie R. Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Palmer / Sister 9417 Fontana Drive Lanham, MD 20706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Denation 5 ☐ Other (Specify) Sep.17,2005 Glenwood Cemetery Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy Street NW Washington, DC 20011 10 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, RENAL CANCER, CEREBROVASCULAR ACCIDENT, DEPRESSION 1 ☐ Yes 2X No 3 Probably 4 Unknown Be Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 2 No 1 ☐ Yes 2 X No 1 TYes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 X No Other: X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tapl Smits 00058776 September 14, 2005 ans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Varnum Street NE #213 Washington, DC 20017 Doris Bustos, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature. State Registrar SEP 1.6 2005

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	lealth a Death	and M	ental Hyg	iene 0	05	3188	7
2	Physici		1. Decedent's Name (First, Middle, L George Charles Wa	,		·					2. Date of Dea Month Septemb	th Day	Year 2005	3. Time of Death)
	/Medic Examir		4a. Facility Name (If not institution, gi		ber)		4b. City	, Town, o	Location of	of Death	Берсешь	4c. County		2.10an	1
-33		ordina.	Shady Grove Adver					ckvi1				Montg	gomer	У	
	Funeral Director		547-21-4167	Sex 7 123 M 2 ☐ F	'. Age (In yrs.	(ast birthday) Yrs.	If Unde Months	or 1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Day, Jan. 2,	Year)	Cour	lace (State or Fore htry) yland	ign
	land wo		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limi	its
	Mary B-f sh	tor	Maryland Montgo	merv	G	aither	sbur	g						1 ☐ Yes 2X	10
	or 28	Director	10e. Street and Number				1	ip Code			1	0g. Citizen of \	What Cour	itry?	
	ath w	rall	877 Clopper Road					878				United			
21215-0036	d within 72 hours after death with the Maryland jiehe. I than "natural", or items 23a or 28s-f show Ite Medical Examinational be multified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? 2 ⊠ No		If Yes, sp	edent of Hecify Cuba 2 No	ispanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		ck, White,		
<u>5</u>	72 ho	eted	15. Decedent's E			16a. Dece	dent's Usi	ual Occup	ation during most	t of working	30	16b. Kind of B			
2	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	use retired)	OF WORK	,9	_			
-	ē ₹ 2 ₹	e Co	17. Father's Name (First, Middle, Las	<u>4</u>		Fun	erai	Dire		ır's Name	(First, Middle, I	Fune			
Maryland	es 1 and 2 should be fi of Health and Mental H f item 27 is marked ot ir other treumatic ever	To Be	George R. Warner								e A. Po		,0,		
a	and M	-	19a. Informant's Name/Relationship			19b. Mailir	ng Addres	s (Street a			/ Route Number		State, Zip	Code)	
	and and mark		George R. Warner	(Father)	7	3150	Sout	th Ca	meron		nue, Sa				
Baltimore,	or of H		20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3			Place of Dispo cemetery, crem	natory or	ame of other plac	θ)	D	ate	20c. Location -	City or To	wn, State	
	permit. Pages I Department of H Important: If its ony injury or ot		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	-	Met	tropoli	tan	Crema	atory	9/15	705 A	lexand:	ria,	Virginia	_
n m	Dep Impo		Volet HY	Most		1	U Ea	st De	er Pa	ark I	rive)	tal noi	пе		
4. T			23a. art1. Eller the disease, or cor shoot or heart failure. List only Immediate Cause (Final	nplications that ca one cause on ea	used the deat ch line.							est,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	α	ras a consec									½ Years	
	Examiner		Conventially list and dains	b	. 40 4 0011000	400.000 0.7.									
	pe is	Iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying		r as a consec	quence of):									
	ficate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	ras a consec	uence of):				_			===		
8/60,	e be e sicien e buria	dlcal E	(. d		,									
٥	tificati ng phy as the	0 1		0.											
X D	death certificate be executed e attending physicien and d for use as the burial-transit	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnath 2 Peta	ancy al death 3 [Ectopic p	pregnancy					e of delive	,	
5	uires that the death certific signed by the attending p d be detached for use as	Physician/M	1 Yes 2 No	4□Pregna 9□ Unknov	nt at time of c vn	death 5	Other (s	pecify)				Мо	nın	Day Year	
ī.	requires that the een signed by th nould be detache		Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the ur	nderlying	cause give	n in Part I.		23e. Did tob	acco use conti	ribute to th	e cause of death?	
Records,	quires an sign uld be	ed by	Aspiration Pneum	onia							1 🗌 Ye	s 2 No	3 Prob	ably 4 Unknow	m
ပ္သ	S S D	ompleted									24a. Was ar		Vere auto	osy findings availab	le
_	ate pag	Сош									autops perform	ned?	death?	npletion of cause of 2□ No	
N [a	ding Physicien: h. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	· ·		Check only on				
5	Phys r this ral dir	To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 🔀 In		ER/Outpatien 28b. Time of			4 🗀 Nur		ne 5 ☐ Reside			')	
0	Attending Physicien: r death. ector: After this certific. by the funeral director,	atlor	1 Accident 5 Pending 2 Accident investigation	(Month	, Day Year)	Injury	м	28c. Injury Work 1 [] \	:? ∕es 2 □ N				-		
DIVISION	tal or Attends safter death	Certification:	3 Suicide 6 Could not 4 Homicide determined	289. Place C	of Injury - At h	ome, farm, stre	eet, factor	ry, office		2	8f. Location (Sti City or Town	reet and Numb , State)	er or Rura	Route Number,	_
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the funerel in the funerel by the	edical	29a. Certifying P	hysician: To the b miner: On the bas and manne	is of examina	owledge, death	occurred estigation	at the tim	e, date and pinion, deat	d place, a n occurre	nd due to the ca d at the time, da	use(s) and ma	nner as st and due to	ated. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	, <	-0_		29	c. License	number		29	d. Date signed	(Month, I	Day, Year)	
	10		1 Junge	<u> </u>	240	5		4308	3		S	Septemb	er 15	, 2005	
			30. Name and address of person who					JI -	200 -	D = -1		m 2005			
- 3	Sta	te	George A. Sotos, 31. Date filed (Month, Day, Year)	329 Re	gistrar's Signa	ature Loc	er D	I. #.	, I	KOCKI	/IIIe, M	ш 20850	J		
	Registr	_	SEP 1.6 21	005	us B	COS									

			State of Marylar	nd / Depa		ealth and M	Mental Hyg	•	
*		1. Decedent's Name (First, Middle, Last)					2. Date of Dear		3. Time of Death
Physic /Med			BER				SEPT.	13 200	5 1408 M
Exam	iner	4a. Facility Name (If not institution, give si		CENTER	4b. City, Town, or L	Time 2		4c. County of De	ath 7
- Funera		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign
Directo		215-42-2927	M 20XF 60	Yrs.	Widitiis Days	HOGIS MIII.	Dec 11	1944 Le	esburg, VA
iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
Many e-fah	tor	MD Frederic	k Kı	noxvil1	Le				1 ☐ Yes 2 ☑ No
with the	I Director	10e. Street and Number 916 Harpers Ferry	Road		10f. Zip Code 21758	}	1	0g. Citizen of What 0	Country?
death	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Wh	
is 5, intally fall of LLT. COOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	è	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ★No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No		, riodii, oto.,		hite
72 hc	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion iring most of worl	king	16b. Kind of Busines	s/Industry
within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ıstodian			Ft. Detri	lck, MD
e filed I Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, i	Maiden Sumame)	
Menta Menta mrked artic e	To E	Harold Oliver Dan	ner			Doris 1	Mae Hall		
12 sho	1	19a. Informant's Name/Relationship (Type Kenneth D. Webber	· ·	1	-			r, City or Town, State,	
1 and 1 and Healti tem 27		20a. Method of Disposition			sition (Name of natory or other place)			20c. Location - City of	
Pages ent of nt: if if		1 ☐ Burial 2 ②Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Ha	semetery, cren gerstot	matory or other place) wn Cremato	ry 9/1	7/05	Hagerstown	n, MD
partitions, in pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra		21. Signature of Fineral Service License	William	Jo	Name and Address	liams F	uneral H	ome	
N W		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deal	th. Do not ent	00 Petersy er the mode of dying,	ille Ro such as cardiac	ad, Brun or respiratory arr	swick, MD	Approximate
Physician		Immediate Cause (Final disease or condition	CELEBRAL		sigh A				Interval Between Onset and Death
/Medica Examine	1	resulting in death)	Due to (or as a consec						
LAdillile		Sequentially list conditions b.	Due to (or as a consec	mence of):					
uted d ansit	Examiner	b. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		, 20.1.00 0.7,					
rou, le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
ate be ex hysician the buria	lcal	d.							
certific ding p	/Mec	IF FEMALE:	sc. If yes, outcome of pregna	ancv				23d. Date of d	alivary
res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			Month	Day Year
s that	by P	Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	nderlying cause given	in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
w require							1 🗆 Ye	es 2,1⊠(No 3∏ F	Probably 4 Unknown
law has b	Completed					7.00	24a. Was a autops perform	sy prior to med? death?	autopsy findings available completion of cause of
cian: cian: ertific	Be (25. Was case referred to medical examiner?					th (Check only on	00)	
Physic rthis rat dir	٠. ا	1 Yes 2 No	ospital: 1 Minpatient 2 ☐ 28a. Date of Injury	28b. Time of		4 Nursing H		ence 6 Other (Sp ow injury occurred	ecify)
Attending r death.	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work?	es 2 □No		, ,	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Attenthis certificate completely filled in by the funeral director, pag	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia		eet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
Hospite 24 hours Funeral	dical C	29a. Certifier 1 Certifying Thysology (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge death ation and/or in	continued at the time vestigation, in my opin	, data and place nion, death occu	, and due to the s rred at the time, d	ate and place, and do	e stated.
To the within Fo the comple	Medi	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
0		>9/m n	10		P 17	672		Sept 13	2005
1,1		30. Name and address of person who cor	mpleted cause of death (Iter	n 23a) (Type,	Print) EVDV	ine Fonta	nilla		
		31 Date filed (Month, Day, Year)		BACTI.A	INE MA	rcylando	2120	1	
Regis	itate strar	31. Date filed (Month, Day, Year) SEP 192	005 Marie	JE A	porte				

		State of Maryland / Department of Health and 1- State of Maryland / Department of Health And 1- State of Maryland / Department of Health And 1- State of Maryland / Department of Health And 1- State of Maryland / Department of Health And 1- State of Maryland / Department / Depar	Mental Hyg 4/05dhb	giene 199, 2005 31889
Physicia	an	1. Decedent's Name (First, Middle, Last) MILLELE FATE WILSON	2. Date of Dea Month	th Day Year 3. Time of Death 2005
/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Death
Examin	- I	UNIV. MANYLAND WED CTR. BALTIMONE		
- Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr. Months Days Hours Min	. (Month, Day	(, Year) Country)
Director		213-78-5402 1 M 2 M F 44 Yrs. Wolfuls Days 16615	Jan 8,	1961 Maryland
yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mar Fire	ctor	Maryland Harford Havre de Gra	ice	1 X Yes 2 □ No
or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
e 23e	Fal	650 Franklin Street, Apt 2 21078 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Ves or No.	USA 14. Race - American Indian,
re, Maryland 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene is not theme 23e or 28e-1 show other treumatic event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Specify Cuban, Mexican, Pue If Yes, Give Year or Dates:	into Rican, etc.)	Black, White, etc. Specify: Black
21215-0036 de within 72 hours afragiene. The matural; or the Madical Exprin	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	orking	16b. Kind of Business/Industry
Maryland 2121: 2 should be filed within in and Mental Hygiens 1 semerked other than "reumetic event, the Mas	mo	Elementary/Secondary (0-12) College (1-4or 5+) 9 College (1-4or 5+) Domestic		Hotels
nd indicate the file of the vent,	BeC		ame (First, Middle,	Maiden Sumame)
ylaı buld b Menti	0		ia Ann Ga	
Maryland Id 2 should be file In and Mental Hy If is marked but treumatic event		19a. Informant's Name/Relationship (Type, Print) Patricia A. Pringle / mother 46 Saturn Drive, Hav		
ore, M		20a Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar popartment of Hea important: if team any injury or othe			19/05	Chestertown, MD
Bal permii Depar Impou		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott F 552 Lewis St	uneral Ho	ome, P.A. vre de Grace, MD 21078
Box 68760, ath certificate be executed Examiner. Ittending physician and for use as the burial-transit for use as the burial-transit.	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LEFT INTRALAVIAL HEMMIN hugg v Due to (or as a consequence of): CARUSPATHY ON GUMANIN Due to (or as a consequence of): CARUSPATHY ON GUMANIN CARUSPATHY CARUSPATHY CERTIFIED CARUSPATHY CERTIFIED CONTROLOR IN HUGGE V Due to (or as a consequence of): CARUSPATHY CERTIFIED CE		Onset and Death Onset and Death MEDICAL EXAMINER
	·			
of Vital Records, P.O. Box 6 Physician: The law requires that the death certificate has been signed by the attending rall director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
IS, P IS, P igned be detailed	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
cords	edt	COCAINE ASUSE With Cerdiomyopathy AND	1 □ Y	es 2 No 3 Probably 4 Donknown
for ME Vital Record sicien: The law requir certificate has been si irector, page 2 should	Completed	Syrape	24a. Was a autop perfor 1 🗌 Yes	sy prior to completion of cause of
/ita	Be	examiner?	eath (Check only or	
Of Of Phys	7	27 Manner of Death 28a Date of Injury 28b. Time of 28c Injury at		ence 6 Other (Specify) ow injury occurred
Division or Division of lor Attending Pharmachean attendent attention to be to	Certification:	27. Manner of Death 1 Natural 5 Pending The decident investigation 28. Date of Injury 28. Time of FOUND 28. Injury at Work? 1 Yes 2 No	FALL P	UNKNOWN
Visi Visi Atter	ifice	3 Suicide 6 Could not be determined 28e Place of Injury - At home farm, street, factory, office building, etc. (Specify)	28f. Location (S	treet and Number or Rural Route Number, n, State) FOUND
ritel or ral Direction		ATHOME	650 FA	anklin St. Horve Degrace
Division of Vital Re Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the place 2 Medical Examiner: On the basis of examination and occurred at the place 2 Medical Examiner: On the basis of examination and occurred at the place 2 Medical Examiner: On the basis of examination and occurred at the place 2 Medical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis	ce, and due to the c curred at the time, c	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comp	Me	29b. Signature and Little cycentrier 29c. License number 16541	2	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASEY Thomas 2L S. Greene C.L. Kalkinia	~ Ms	21201
Sta Registr		31. Date filed (Month) Day Year) 5 82005 (32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 6 per Th 884/9-29-05 vt
State of Maryland / Department of Health and Mental Hygiene

Per FH G84/9/29/05 Certificate of Death

Reg. No. 1 C 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** NATHANIEL EARL WRIGHT SEPTEMBER 22ND, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) FEB 7 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 ☐ F Yrs. MARYLAND 64 1941 216-38-1757 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Directo MARYLAND ALLEGANY CRESAPTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13215 FIFTH AVENUE, SW 21502 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 21X Married 1 ☐ Yes 2 ☒ No WHITE Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MASTER PLUMBER/PIPE FITTER 12 PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARTHUR WRIGHT ELIZABETH STRES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13215 FIFTH AVE., SW, CRESAPTOWN, MD 21502 VIRGINIA WRIGHT / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 9/25/05 FROSTBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET MO6547 SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 owers. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRYTHMIA MINUTES disease or condition resulting in death) Due to (or as a consequence of): CORONARY ARTERY DISEASE YEARS Sequentially list conditions. Dive to (brias a consequence of): day, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner be executed

and

the attending physician

been

certificate has

this

the Hospital or Attending

2

death.

after death Diractor:

within 24 hours a To the Funaral L

Medical

Box 68760

P.O. I

Division of Vital Records,

Funeral

Director

28a-f show

ö

Itams 23a

"natural", or

e filed within al Hygiene.

permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event 9008:

Baltimore, Maryland 21215-0036

traumatic event, the Medical Exacilitat retriust be notified at

use as the burial-transit ło detached signed by t Completed Be 2 Certification:

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No vvas arī autopsy performed? res 2X No 2 💢 No 1 Yes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Cal

Hospital:

D0054411

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) SEPTEMBER 23RD, 2005

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers

28a. Date of Injury (Month, Day Year)

CALKINS, BEVERLY M. M.D., 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502 32. Pegistrar's Signature

31. Date filed (Month, Day, Year) State SEP 2 9 2005 Registrar

25. Was case referred to medical

2**X** No

5 Pending

investigation

6 Could not be determined

examiner'

1 ☐ Yes

27. Manner of Death

2 Accident

4 - Homicide

(Check only one)

3 Suicide

29a. Certifier

1 X Natural

1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Physicia /Medic Examine uneral		1. Decedent's Name (First, Middle, Last,						No200	
/Medic Examine uneral	111)				2. Date of Death Month	Day Yea	3. Time of Dea
Examine uneral	al	Delores Jean Wi	nk				Sept.	17 200	1 / 6
uneral		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of De	eath
	4	Washington Cou	mtu Voqnita	1	Hagerst	own		Washing	ton County
		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		Birthplace (State or Fo. Country)
irector		164-34-2134]M 2[X F	62 Yrs.	Months Days	Hours Min.	March 26		ennsylvani
-		Usual Residence of Decedent					1 101 210	-1313-1	CIPIDYIVAIII
Mov.		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Li
r than "natural", or iteme 23e or 28e-f ehow the Medical Examinar must be notified at	ţ	Maryland Washingt	on	T	agerstow	n			1 ☐ Yes 2X
128	rec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
380	Funeral Director	11712 Mockingbird	l Lane		2174	2	Un	ited Sta	tes
70 Z	ere	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		merican Indian,
= =	ᆵ	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 No				Rican, etc.)	Black, W	_
2	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
a tura		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation	16	b. Kind of Busine	ss/Industry
	Set	(Specify only highest grad		(Give	kind of work done DO NOT use retire	during most of work	king		
than	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	Tnda	nandant [Theorem 1 Am		C-16 E	1
2 =		17. Father's Name (First, Middle, Last)		THOE	pencent.	Travel Age 18. Mother's Nam	ne (First, Middle, Ma	Self Emp iden Sumame)	тоуеа
U .	Be	Garnet E. Helman					Belle Bin		lman
natk	ဥ	19a. Informant's Name/Relationship (T)	una Firinti	10h Maili	an Address (Street		ral Route Number, C		
7 is marke treumatic		Larry Ross Wink S	* * *					-	land 21742
item 27 other tre	ij.			Ob. Place of Dispo				c. Location - City	
= 5		20a. Method of Disposition 1 ◯XBurial 2 ◯ Cremation 3 ◯ F	Communitrom State	cemetery, cre-	matory or other pla	ice)		•	
		4 ☐ Donation 5 ☐ Other (Specify)		Rest Hav	en Cemete	ery Sept	21 05 H	agerstow	n Maryland
Importent: i any injury o once.	1	21. Signature of Funeral Service Licens	ee 7.	2	2. Name and Addre	ess of Facility DO	uglas A. i	Fierv Fu	neral Home
any ir	1	VI Junator	Vien	/ 1	331 Easte	ern Blvd.	N. Hager	stown Ma	ryland 217
×		23a. Part1. Enter the disease, or compleshock, or heartfailure. List only o	ications that caused the						Approximate Interval Between
	1	Immediate Cause (Final							Onset and Deat
sician edical		disease or condition resulting in death)			Dreat	Conce.	-		10 489
miner		- (Due to (or as a cor	nsequence or):					
\$ 1	-	Sequentially list conditions,	b. Due to (or as a cor	escuaina di					
isit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	203 10 (0. 20 200						
sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):					
urial			Due to (or as a cor	isaquarica oi),					
	licai		d						
anding phy use as th	Med	IF FEMALE:						-	
endi	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		☐Ectopic pregnanc	ev.		23d. Date of	•
e atter	0	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time		Other (specify)	,		Month	Day Year
ache	hys	9 Unknown	9□ Unknown						
ed by the a	by P	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute	to the cause of death
ng pa	P P						1 ☐ Yes	2 No 3	Probably 4 Unki
been si should	Completed						240 1400 00	Joh Wass	autana findana au
	du						24a. Was an autopsy performe	prior	autopsy findings avai to completion of cause
page 2	Ö								es 2□No
certificate rector, pag	Be (25. Was case referred to medical examiner?					th (Check only one)		
± 9	2	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Ott	her: 4 🗌 Nursing Ho	ome 5 Resident	e 6 Other (S	pecify)
ter th		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injui	ry at	28d. Describe how	injury occurred	
r: Alter e funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(пусту		Yes 2 □No			
oy th	5	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, st	reet, factory, office		28f. Location (Street	et and Number or	Rural Route Number,
in the	ert	4 Homicide	building, etc. (S	ресіту)			City or Town, S	State)	
fillec		29a. Certifier 1 Certifying Phy	rsician: To the best of my	knowledge deal	h occurred at the ti	ime, date and place	and due to the caus	se(s) and manner	as stated
• Funerel Direc letely filled in by	lica	(Check only 2 Medical Exami	iner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my	opinion, death occur	rred at the time, date	and place, and o	lue to the cause(s)
To the Funerel Director: completely filled in by the	Medicai		and manner stated.		29c. Licens	se number	294	. Date signed (Mo	onth Day Year)
000	-	29b. Signature and title of certifier	0	4.4 4			290		
		Muchael of				41667		9.17.	
5		30. Name and address of person - o c	ompleted cause of death	(Item 23a) (Type	Print)				
. Y)		Michael MC	Cormerk	11110	media	cal Can	nos la	Licrit	in MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. 2.005 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First Middle Last) Dav Month Year 2225 PM **Physician** Wilson Weldon September 10 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner River Hospital hesterto wn Center Kent If Under 1 Year | If Under 24 Hrs. 6. Sex 102 M 2□ F A Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Hours 5 Months 5 216-56-135 Director Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show if Health and Mental Hygiene. itam 27 Is marked other than "neturel", or Items 23s or 28e-1 show other traumatic avent, the Medical Examination to trutified at 1 Yes 2 No Queen Anne's Director entreville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 720 2 oon Box Road 161 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, the Me College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing 2 Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Wilson George DuBois Anna Bell ٩ Jacobs 19a. Informant's Name/Rela onship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.BOX 551-TRappe Maryland 216/ 21673 Shelton Wilson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/17/05 Burrisville, 4 □ Donation 5 □ Other (Specify) Burrisville Cometery 21. Signature of Funeral Service Licensee 22. Name and Address of acility Henry Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of ying, such as cardi to or respiratory arrest,

Approximate

Immediate Cause (Final Immediate Cause (Final disease or condition resulting in death) Priysician Onlmonar TENJID m /Medical Due to (or as a con quence of): **Examiner** sarcoido Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year ö in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9□ Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 3□ DOA Date of Injury
(Month, Day Year) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 10 1 🗌 Yes completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Morth, Day, Year) 29b. Signature and title of certific am

DHMH 17 Rev 1/2001

State Registrar 30 Name and address of person who co

inpleted cause of death (Item 23a) (Type, Print)

			For State Registrar		State o	of Marylan	d / Depa <i>Cei</i>	artment of I tificate of	lealth ar <i>Death</i>	nd Mental Hy	giene 005	31893
_	Physicia	an	Decedent's Name (First, James K			na				2. Date of De	mber17,200	3. Time of Death
	/Medic Examin		4a. Facility Name (If not ins					4b. City, Town, o	or Location of		4c. County of De	
			214 Virginia					Cambri	_		Dorchest	
- 8	Funeral Director		5. Social Security Number 243–30–1323		Sex 1.27_M 2.□F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Da	ly, Year)	irthplace (State or Foreign Country)
	9		Usual Residence of Deced				-			May 10,	1921 NO	rth Carolina
1	Maryland f show	ō	MD Do	ounty orche	ster	10c. Cir	y, Town or Lo	Cambrid	dae			10d. Inside City Limits 1 Yes 2 □ No
de	with the P a or 28e- be notifi	irect	10e. Street and Number					10f. Zip Code			10g. Citizen of What 0	Country?
18	death with	ralD	214 Virgi	nia A	ve.				21613		USA	
386	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other treumetic evant. Its Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Div		Armed F	2 🗆 No	_ .	Vas Decedent of I Yes, specify Cub □ Yes 2 No		n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	in 72 hol "natura Aedical E	Completed	(Specify only		ade completed)		16a. Decec (Give life. L	lent's Usual Occup kind of work done OO NOT use retire	pation during most o	of working	16b. Kind of Busines	s/Industry
212	giene.	Com	Elementary/Secondary (I	0-12)	College (1-4or 5+)		ruck dri			oil comp	any
land	Id be fils lental Hy kad oth ic evant	To Be (17. Father's Name (First, M Kenneth Ye		")					s Name <i>(First, Middle</i> lys Weather		
lary	2 shou and M is mar eumet	-	19a. Informant's Name/Re	ationship ((Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Route Numb	er, City or Town, State,	Zip Code)
	1 and 1 Health em 27 thar tr		Wanda Park 20a. Method of Disposition	er	per. r			Virginia	Ave.,	Cambridge	MD 21613 20c. Location - City of	
altimore,	permit. Pages 1 and Department of Healt Importent: If item 2; any injury or other 9		1 ■ Burial 2 □ Crem 14 □ Donation 5 □ Of	ation 3	Removal from	State Oak	emetery, cren Grove	Baptist		9/22/05	Youngsvill	
alti	permit. F Departme Importer any injur		21. Signature of Funeral S			Chu	rch Ce	netery Name and Addre	ess of Facility		neral Home	
8	89888		Brick	· K	und					Cambridge	e, MD 2161	
	Physician /Medical Examiner	ler	23a. Part1. Enter the dises shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any legiting to immediate the conditions in any legiting to immediate	. List only	a Due to	each line.	uence of):			the lung	rrest,	Approximate Interval Between Onset and Death
68760,	licate be exacuted physician and s the burial-transit	edical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	cDue to	(or as a consequ	uence of):					
P.O. Box (law requiras that the death certificate as bean signed by the attending phys? Should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 🗀 Live I	itcome of pregna birth 2 □ Fetal nant at time of de lown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
rds, F	quiras than signad	by	Part II. Other significant co	should be should	etive p	leath but not resu	ulting in the ur	derlying cause giv	en in Part I.		obacco use contribute l res 2 □ No 3 □ F	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	The ate h page	Completed								24a. Was autor perfo 1 \(\text{Yes}		
Vita	Physicien: this certificatal director, I	o Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☑ No	edical	Hospital:	Inpatient 2 🗆	ED/Outpation	3□ DOA Oth		Death (Check only o	dence 6 Other (Spe	
J Of	ding Phys	\vdash	27. Manner of Death	Pending	_	of Injury oth, Day Year)	28b. Time of Injury	28c. Injui	y at		now injury occurred	эсту)
50	Attending r death. actor: After	icatic	2 ☐ Accident i	nvestigatio Could not b	n 100 Rinas				Yes 2 □ No		Street and Mumber or F	Dural Paula Mumbar
Div	ital or Attenurs after deatling Director:	Certification:	4 Homicide	determined	build	ing, etc. (Specif)	/) 		_	City or Tov	,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Ce (Check only 2 Me one)	rtifying Ph dical Exar	miner: On the b	e best of my know asis of examination and stated	wledge, death tion and/or inv	occurred at the tir estigation, in my o	me, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
•	To the I within 2. To the I complet	×	29b. Signature and title of	ertifier	01	M	_ M.D.	29c. Licens	e number		29d. Date signed (Mon $9 - 19 - 0$	*
-			30. Name and address of p	1.	completed cau	se of death (Item 408 B	-	reet Ca	mbrida	e, Maryla	nd 2161	3
	Sta Registra		31. Date filed (Month, Day,	P2	2005 ^{32. F}	Registrar's Signa	ture JG	Joseph) /		

The state of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.												
Physiciai /Medica		1. Decedent's Name (First, Middle, Las	Earl	T.	Busters	ER			te of Death	200	5	Stine (Dan)
Examine		4a. Facility Name (If not institution, give	street and numb	er) Br	iltimore ire cente	4b. City, Town,	or Location of D			4c. County of I	Death	A
Funeral Director	V	215-21-0293	ex 7. Mg 2□ F	Age (la	n yrs. last birthday 73 Yrs.	Months Days	If Under 24 H	Ain. (Mi	te of Birth onth, Day, Ye	1932	Birthpla Count	ace (State or Foreig ry) CYLAND
e or 28e-f show		Usual Residence of Decedent 10a. State 10b. County	1/4	10	Oc. City, Town or L	ocation B n	TIHO	DE	CIT	7/	10	d. Inside City Limits
3e or 28e	Funeral Director	10e. Street and Number	ERSTON	,,),/	BOAN	10f. Zip Code	212	17	10g/	Citizen of Wha	t Count	ry?
0 0 🖆 🗎	by runers	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 (X) Yes 2 If Yes, Give Year or Date	ent Eve es?	er in U.S. 13.	Was Decedent of If Yes, specify Cub		? (Specify Your Rican,	es or No- etc.)	14. Race - Black, Specify:		
	Completed	15. Decedent's Ed (Specify only highest gra	lucation		16a. Deca (Giv. life.	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of ed)	working	16b	. Kind of Busin	ess/Indi	ACK ustry
d oth	De	אוגאניטאו) 17. Father's Name (First, Middle, Last)			n	WORK		Name (First,	Middle, Maid	CAIL (4 = 1
and Men Is marke sumetic	0	19a. Informant's Nam = elationship (19b. Mail	ERS ing Address (Stree			e Number, Ci	ity or Town, Sta		
int of Health t: If item 27 y or other tre		COBERT BUSTER 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from St	ate	cemetery, cre	osition (Name of ematory or other pla		Date		ALTIM Location - Cit		
Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Licensee Name and Address of Facility BROWN JR. FUNERAL HOME 25. SEPH H. TON AVE. BALTO, Mp. 21217										
hysician		28a. Part1. Enter the disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition	plications that cau one cause on eac	sed the	e death. Do not er	nter the mode of dy	ng, such as care	diac or respi	ratory arrest,			Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or	asac	onsequence of):							
ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as a consequence of):									
physicis the bu	edical	(d		-78-7							
the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year				
n signed by the auld be detached I	2	Party, other signment contained to death bat het researing in the underlying cause given in 1 art i.										
certificate has been signed by the attending irector, page 2 should be detached for use as	Completed							-	la. Was an autopsy performed	? prio	r to com	sy findings available pletion of cause of
certific	o ge	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	26. Place of Death (Check only one)								
Attending Physic death. The death. Softer: After this by the funeral di	- 16	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No									
in the hospitel of Attento within 24 hours after death To the Funerel Director: completely filled in by the f	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specify)					cation (Street ty or Town, St	treet and Number or Rural Route Number, n, State)			
n 24 hou n 24 hou ne Funei bletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
within 2 To the complei	5	29c. License number 29c. License number				29d.	29d. Date signed (Month, Day, Year)					
		30. Name and address of person who 3900 Lock R	completed cause	of deat	h (Item 23a) (Type	Print) X/41 Balt	W.RON I	5	SHAU	2121	S	7.02
State Registra	e r	31. Date filed (Month, Day, Year)	32. R	istrar's	Signature	freele		,				

JC O5-06621

Llewelyn Butler Jr.

Amend item#23aPI, perME, G850, 12-30-05 TI

State of Maryland / Department of Health and Mental Hygiene, State of Maryland / Department of Health and Mental Hygiene, Temperature of Death

1- For Amend Item 1&Unpend Item 23a, 27, 28a-1 per me G848 10-18-05 tags () 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** EWELL YL VESTER 29,2005 September 09:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2117 N. Pulaski St. Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 211-84-533 Hours 1**⊠**M 2□F Yrs. Director LAND Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show Itam 27 is marked other then "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No MARYLAND Direct 10e. Street and Number 10g. Citizen of What Country? ASK1 USA. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced BLAC 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 2+#GRADE DECURIT 17. Father's Name (First, Middle, Last) er's Name (First, Middle, Maiden Surname) and Mental LEWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rout Number, City or Town, State, Zip Code) Pages 1 and 2 Itam 27 JACQUETTA D.

20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If Its eny injury or of once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from Sta cemetery, crematory or other place) REMATORY 10-06-05 VOALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Picility 21. Signal of Funeral Service Licensee JR. FUNERAL HOME I-ULTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line and Alcohol Intoxication Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Amitriptyline Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown rthis certificate has been signed by ral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy lindings available autoosy performed? 2 No of-Vital Yes 2 No Attending Physician: : After this certification and funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) YYYes 2∏ No Founds at 7:00 a 28a. Date of Injury Four Marth, Day Year) 9-29-05 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: unk Division 1 Natural 5 Pending death. 1 ☐ Yes 2 No I Director; A d in by the fu investigation \mathbf{a}^{M} 2 Accident 6 XCould not be 3 ☐ Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 2117 N. Pulaski Baltimore, Maryland filled in by 4 | Homicide Pulaski St. ō Found at residence To the Hospital within 24 hours e To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) l G O.C.M.E. September 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ł 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. R State OCT 0 3 2005 Registrar

			1- State of Maryland / E	Department of Heal Certificate of Deal		al Hygien	6002	31896			
			Decedent's Name (First, Middle, Last)			te of Death	0.	3. Time of Death			
	Physici		Bette Jean Burk				ay Year	12 00 DM			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	ptember 4	28, 200 lc. County of Deat						
	Exami	Ŭ.	1210 Mistwood Court #204	Belcamp			Hardord				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If U	Under 24 Hrs. 8. Da	te of Birth onth, Day, Yea	9 Rint	hplace (State or Foreign			
	Director		219-42-1734 1□M 2\\$F 61	Yrs. Months Days Ho				yland			
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10.1.1.1.20.11.11			
	shov	Director	Maryland Harford Belc				10d. Inside City Limits 1 ☐ Yes 2 XNo				
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Menlat Hygiene. If it itam 27 is marked othat than "natural", or itams 23a or 28a-f show it it itam 27 is marked othat than "natural", or other traumatic event, the Medical Exam her must be notified at		10e. Street and Number	10f. Zip Code		100.0	National of 18/6 - 1 Oc				
21215-0036		rai Dir	1210 Mistwood Court #204	21017		10g. C	Citizen of What Co USA	untry?			
	urs after des al', or Itams Examiner m	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 No Sp	nic Origin? (Specify Yelexican, Puerto Rican, pecify:	etc.)	Black, White	14. Race - American Indian, Black, White, etc. Specify: White			
	vithin 72 ho ne. han "natur s Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					ib. Kind of Business/Industry			
2	iled v dygie thar t		12 17. Father's Name (First, Middle, Last)	Homemaker	Mother's Name (First,		wn Home				
	2 should be filed within a and Mental Hygiene. 7 is marked othar than "raumatic evant, the Merc	To Be	Charles Alexander Frey				. Whitte	n			
	1 and 2 sho Health and I am 27 Is me		19a. Informant's Name/Relationship (Type, Print) Scott Burk - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3077 Appleridge Drive, Ann Arbor, Michigan 48103								
Baltimore,	Pages 1 a nent of Hea ant: If itam ury or otha		20a. Method of Disposition 1 Burial 2 In Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory of other place) Hilltop Services Corp 10-3-05								
Balti	permit. Page Department o Important: If any injury or once.	10-3-03									
			23a. Part1. Enter the disease, or complications that caused the seath. Do n shock, or heart failure. List only one cause of each line.	ot enter the mode of dying, su			* Marata	nd 21009 Approximate Interval Between			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ASC VD Due to (or as a consequence or cons	Δ.				Onset and Death			
ŀ	Examiner										
	uted d ansit	Examiner	Sequentially list conditions, tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last resulting in death) Last								
68760,	icate be executed physician and the burial-transit	dical Exa	Due to (or as a consequence of):								
_	tifical og phy as th										
Records, P.O. Box 6 The law requires that the death certif	at the death certific by the attending p tached for use as	Certification; To Be Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year					
	quires that n signed b uld be deta		Part II. Dther significant conditions contributing to death but not resulting in	-			23e. Did tobacco use contribute to the cause 13⊋7es 2 □ No 3 □ Probably 4				
Il Records,			Reactive Airway Dise		a. Was an autopsy performed?						
Vital	Physiclan: Th this certificate ral director, pag		25. Was case referred to medical examiner?		Place of Death (Chec	k only one)					
of	Physi this o		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out		☐ Nursing Home 54			rify)			
	ding F h. After funera		Talifation of the straining	jury Work?		escribe how inju	ury occurred				
Sio	tend death tor: /		2 Accident investigation 3 Suicide 6 Could not be 299 Place of Injury. At home farm street factors office.								
Division	al or Attends after death	Sertifi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rule City or Town, State)								
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To t with To t	S	29b. Signature and title of certifier Ataphania Linder	29c. License num	17909		ate signed (Month				
•	O			- 10007	2701	sep	TEMBER	JU, ALLIS			
r	20 '		30. Name and address of person who completed cause of death (Item 23a) (Stephanie Linder 902 A	rype, Print) verill Rd	Joppa,	MB	21085	30, 200s -			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 3 2005 32. Registrar's Signature	Society	0 0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per 1h 9848 10 19-05 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 31897 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death September^D **Physician** 7:27A LAURETTE CHAMBERS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Blakehurst Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ctober 27, 1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2/0/F 83 Mary Tand Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other trsumatic event. Ite Madical Examinar 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Director Maryland Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (7) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Never Married 2☐ Married 1 □ Yes XX No Specify: Specify þ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Raney Debnam Elizabeth Applegarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B Chambers Son 12 Betty Bush Lane Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 20. Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Greenmount Cemetery 9/30/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral S 6500 York Road Baltimore, Maryland 21212 enns XII 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final Neumonis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d, Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Syndxome 2 No 1 TYes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 Yes 2 No To the Hospital or Attending Physicisn: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 70 this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the t within 24 hours after death To the Funers! Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified September 29, 2005 D33401

State Registrar 32. Registrar's Signature

6301 North Charles Street Baltimore Md 21212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Iglehart MD

W

Iredell

31. Date filed (Month, Pays Year) 05

hysici /Medio	196	 Decedent's Name (First, Mid 	Idle, Last)							te of Death	Day	Year	3. Time of Death
	2	Martha A.	Combe						1		er 16,	2005	4:17 PM
xamir	cr (4	4a. Facility Name (If not institut					4b. City, Town, o	r Location	of Death		4c. County	of Death	
	60 g	Montgomery 5. Social Security Number	y Gener		spital Age (In yrs. last I	hirthdayl	01ney	If Under	24 Hrs. 8 Da	te of Birth	Mont	gomery	r ace (State or Forei
neral ector		579-16-3949	1 M		91	Yrs.	Months Days	Hours	Min. (Mo	27		Counti	sylvania
>		Usual Residence of Decedent 10a. State 10b. Coun			10c. City, To	own or Lo	cation						d. Inside City Limi
ehov m	5		gomery		,		Spring					10	1 □ Yes 2√2 N
28a-	Funeral Director	10e. Street and Number					101. Zip Code			10	g. Citizen of V	What Count	ry?
38 0	O	3453 S. Leisu	re Wor	1d B1v	d		20	906			US	A	
ELC.	ner	11. Marital Status	12.	Was Deceder Armed Forces	nt Ever in U.S. s?	13.	Vas Decedent of H	lispanic Ori an, Mexicar	igin? (Specify Yen, Puerto Rican,	es or No-		e - America ck, White, e	
an "netural", or Items 23a or 28a-f ehow Medical Extruitier oust be hollified at	by Fu	1 ☐ Never Married 2 🗓 M 3 ☐ Widowed 4 ☐ Divorc	arried	1 ☐ Yes 2 No If Yes, Give Year or Dates	₹ No		☐ Yes 2∏ No	Specify:			Specify		
al Ex			ent's Education			Sa. Dece	ent's Usual Occup	oation			16b. Kind of Bu		
e di	Completed	(Specify only high	hest grade co	College (1-4o		(Give	kind of work done OO NOT use retire	during mos	st of working				,
other than ant, it a M	mo	12	.,	4		civi	1 servic	e sup	ervisor		Forestr	у Дер	t
d other	Be	17. Father's Name (First, Middle							er's Name (First,				
tem 27 is marked other the other traumatic event, its	2	Jacob Kelle				01 14 77	A 1 1 (O)	l	orence M				2-4-1
27 is π r trauπ		19a. Informant's Name/Relatio		Print)			g Address (Street						20 <i>0e)</i>
item 2 other		Jacki Blunck/r	ilece_		20b. Place	of Dispo	Newbold sition (Name of		Date	-	MD 208 20c. Location -		vn, State
= =		1 ☐ Burial 2 ☐ Crematio 4 ☒ Donation 5 ☐ Other		oval from Stat	te ceme	itery, crei	natory or other pla	cθ)					
Important: I eny Injury o once.		Pi. Signature of Funeral Servi	STORY OF THE STORY	Ha		22	. Name and Addre	ss of Facili	ity		D - 1 - 4		
<u> </u>		Minis	J. May	11	rector		ate Anat ltimore,) W	Baltimo	ore St	reet
*		23a. Part1. Enter the disease,	or complicati	ions that caus	sed the death. D					ratory arre	est,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition		_	gestin	v c	teunt	In.	(Onset and Death
edical		resulting in death)	a . −		as a consequence				10000				
miner		Sequentially list conditions	b	Aon	-	Sile	ma 515						
	ine	Jequeritiany not conditione,		Due to tor a									
isit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	0	as a consequenc	,	. A . (7		_			
and al-transit	xam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Cor	as a consequence	ب-	World	3 0	L384 30	_			
sician and burial-transit	ai Examiner	that initiated events	(a.	Cor	Zonia	ب-	Mola	3 0	6384 SC	-			
g physician and as the burial-transit		that initiated events	c	Cor	Zonia	ب-	Arla	3 0	L384 30				
ending physician and use as the burial-transit		resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d23c.	Due to (or a	as a consequence	ce of):	Marker		L3EU 36			te of deliver	,
attending p for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c d 23c.	Due to (or a	as a consequence me of pregnancy 2 Fetal deat at time of death	ce of):	Dectopic pregnanc		L384 38				y Day Year
by the attending parched for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Due to (or a	as a consequence me of pregnancy 2	ce of): ath 3[Other (specify) _	у			Mo	onth [Day Year
gned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond	litions contrib	Due to (or a	as a consequence me of pregnancy 2 Fetal death a time of death	ce of): ath 3[Other (specify) _	у		3e. Did tob	Mo pacco use cont	ribute to the	Day Year a cause of death?
gned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	litions contrib	Due to (or a	as a consequence me of pregnancy 2 Fetal death a time of death	ce of): ath 3[Other (specify) _	у	1. 2:	3e. Did tob 1 □ Ye	Mo pacco use cont ps 2 □ No	onth [ribute to the 3 ☐ Proba	Day Year e cause of death?
s been signed by the attending p should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond	litions contrib	Due to (or a	as a consequence me of pregnancy 2 Fetal death a time of death	ce of): ath 3[Other (specify) _	у	1. 2:	3e. Did tob 1 □ Ye 4a. Was al autops	Mo pacco use cont os 2 □ No	ribute to the	Day Year a cause of death? bly 4 □Unkno
te has been signed by the attending p age 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond	E. b.	Due to (or a	as a consequence me of pregnancy 2 Fetal death a time of death	ce of): ath 3[Other (specify) _	y ven in Part	1. 2:	3e. Did tob 1 Yes autops 2 perform Yes 2	oacco use control is 2 □ No control is 2 □ No control is 24b.	onth [cribute lo the 3 ☐ Proba	Day Year a cause of death? bly 4 Unkno sy findings availa pletion of cause
te has been signed by the attending p age 2 should be detached for use as	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conductions are presented to med examiner?	E. b.	Due to (or a	as a consequence me of pregnancy 2 Fetal death at time of death but not resultin	ath 35	Other (specify) _	y ven in Part	1. 2: 2. 1[e of Death / Che	3e. Did tok 1 Yes 4a. Was a autops perform Yes 2 ck only on.	oacco use cont os 2 □ No ny y ned?	onth [Day Year e cause of death? bly 4 Unknown sy findings availa pletion of cause 2 No
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond	ical Hos	Due to (or a	as a consequence me of pregnancy 2	ce of): ath 3[Other (specify) nderlying cause gr	y ven in Part 26. Plac her: 4 \square N	I. 2: 24 1[e of Death Che ursing Home 5	3e. Did tob 1 Yes 4a. Was are autops perform Yes 2 ck only one	oacco use cont os 2 □ No ny y ned?	were autopprior to comdeath?	Day Year e cause of death? bly 4 Unkno sy findings availa pletion of cause 2 No
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per	ical Hos	Due to (or a	as a consequence me of pregnancy 2 Fetal death at time of death but not resultin	ath 35	Other (specify) nderlying cause grant 3 DOA Other (specify) 28c. Inju	y ven in Part 26. Plac her: 4 \square N	I. 2: 1[e of Death / Che ursing Home 5	3e. Did tob 1 Yes 4a. Was are autops perform Yes 2 ck only one	Monacco use control of the second of the sec	were autopprior to comdeath?	Day Year a cause of death? bly 4 Unkno sy findings availa pletion of cause
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident inversions	ical Hos	Due to (or a Due t	as a consequence The of pregnancy 2 Fetal death at time of death but not resultin attent 2 ER/ njury Day Year) Injury - At home	ce of): ath 3[Other (specify) nderlying cause grant 3 DOA Other (specify) 28c. Inju	y ven in Part 26. Plac her: 4 N ry at rk? Yes 2	1. 23 16 of Death / Che ursing Home 5 28d. D	3e. Did tob 1 Yes 4a. Was an autops perform Yes 2 Ck only one Reside escribe how a cation (St.)	Moderate and Number an	onth [ribute to the 3 Proba Were autopprior to come death? 1 Yes 2 ner (Specify, red	Pay Year a cause of death? bly 4 Unknor sy findings availa pletion of cause 6
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Per 2 Accident 3 Suicide 6 Cou	ical Hos	Due to (or a Due t	as a consequence me of pregnancy 2	ce of): ath 3[Other (specify) _ nderlying cause gra at 3 □ DOA Other 28c. Inju Wo M 1 □	y ven in Part 26. Plac her: 4 N ry at rk? Yes 2	1. 23 16 of Death / Che ursing Home 5 28d. D	3e. Did tob 1 Yes 4a. Was a autops perform Yes 2 ck only on. GReside escribe ho	Moderate and Number an	onth [ribute to the 3 Proba Were autopprior to come death? 1 Yes 2 ner (Specify, red	Day Year e cause of death? bly 4 □Unknor sy findings availal pletion of cause of
this certificate has been signed by the attending p al director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condexaminer? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Per 2 Accident 3 Suicide 6 Coudet 1 Coulong 1 Countries 1 Countries 2 Countries 2 Accident 3 Suicide 6 Coudet 2 Countries	ical Hosi ading astigation ald not be emined	Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to building to death (Month, i 28e. Place of building, ian: To the bes: On the basis	as a consequence me of pregnancy 2 Fetal dect t at time of death h but not resultin atient 2 ER/ njury Day Year) Injury - At home etc. (Specify) est of my knowled s of examination	ath 3[n 5] g in the u (Outpatie) b. Time of Injury , farm, st	Other (specify) _ nderlying cause gra at 3 □ DOA Other 28c. Inju Wo M 1 □	y ven in Part 26. Plac her: 4 N ry at rk? Yes 2	I. 2: 2e of Death / Che ursing Home 5 28d. D]No 28f. Lc Cr nd place, and du	3e. Did tob 1 Ye 4a. Was a autops perform Yes 2 ck only one Pescribe horizontal (Str. by or Town 1e to the ca	Moderate And Number 1, State)	iribute to the 3 Proba Were autopprior to comdeath? 1 Per (Specify, red	Poute Number,
this certificate has been signed by the attending p al director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond examiner? 1 Yes 2 No 25. Was case referred to med examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 28. Certifier (Check only one) 29a. Certifier 2 Medic	ical Hose anding astigation ald not be termined frying Physicial Examiner	Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to built) Due to (or a Due	as a consequence me of pregnancy 2 Fetal dect t at time of death h but not resultin atient 2 ER/ njury Day Year) Injury - At home etc. (Specify) est of my knowled s of examination	ath 3[n 5] g in the u (Outpatie) b. Time of Injury , farm, st	other (specify)	y ven in Part 26. Plac ther: 4 N In N I	I. 2: 2e of Death / Che ursing Home 5 28d. D]No 28f. Lc Cr nd place, and du	3e. Did tob 1 Yes 4a. Was autops perform Yes 2 Cck only one i Reside escribe ho coation (St. fy or Town te to the ca he time, di	Modern Mo	anth [iribute to the 3 Probate of Probate of Specify, red]	Day Year e cause of death? bly 4 Unkno sy findings availa pletion of cause 2 No Route Number, atted. the cause(s)
s certificate has been signed by the attending p director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ical Hospitalian H	Due to (or a Due t	as a consequence me of pregnancy 2 Fetal dect t at time of death h but not resultin atient 2 ER/ njury Day Year) Injury - At home etc. (Specify) est of my knowled s of examination	ath 3[n 5] g in the u (Outpatie) b. Time of Injury , farm, st	other (specify)	y ven in Part 26. Plac ther: 4 N N N N N N N N N N N N N	l. 2: 1[e of Death //Che ursing Home 5 28d. D]No 28f. Lc Ci and place, and du ath occurred at the	3e. Did tob 1 Yes 4a. Was autops perform Yes 2 Ck only on Grant Reside escribe ho bocation (Stry or Town te to the ca he time, di	Moderate and Number, State) Moderate and Number, State)	iribute to the 3 Proba Were autopprior to comdeath? 1 Pres : are (Specify, red	Poay Year Pacause of death? Poul of Cause of death? Poul of Cause of death? Poul of Cause of death? Poul of Cause of death? Poul of Death of Cause of death? Poul of Death of Cause of death? Poul of Death of Deat
this certificate has been signed by the attending p al director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condexaminer? 1 Yes 2 Xex	ical Hospital	Due to (or a Due t	as a consequence The of pregnancy 2 Fetal death at at time of death but not resultin atient 2 ERV njury Day Year) Injury - At home etc. (Specify) asst of my knowlets s of examination stated.	/Outpatien b. Time c Injury farm, st dge, deat	other (specify)	y ven in Part 26. Plac ther: 4 N N N N N N N N N N N N N	I. 2: 2e of Death / Che ursing Home 5 28d. D]No 28f. Lc Cr nd place, and du	3e. Did tob 1 Yes 4a. Was autops perform Yes 2 Ck only on Grant Reside escribe ho bocation (Stry or Town te to the ca he time, di	Modern Mo	iribute to the 3 Proba Were autopprior to comdeath? 1 Pres : are (Specify, red	Poay Year a cause of death? bly 4 Unkno sy findings availa pletion of cause 2 No Route Number, tted. the cause(s)
this certificate has been signed by the attending p al director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond examiner? 1 Yes 2 No 25. Was case referred to med examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 27. Manner of Death 1 Natural 5 Per 2 No 28. Certifier (Check only one) 29a. Certifier 2 Medic	ical Hospital	Due to (or a Due t	as a consequence me of pregnancy 2 Fetal dect t at time of death h but not resultin atient 2 ERV njury Day Year) Injury - At home etc. (Specify) ast of my knowled s of examination stated.	ce of): ath 3[b. 5[continue of the contin	other (specify) nderlying cause grant 3 DOA t 3 DOA t 28c. Inju Wo 1 eet, factory, office an occurred at the tree vestigation, in my 29c. Licen.	y ven in Part 26. Plac her: 4 N ry at rk? 1 Yes 2 N ime, date a opinion, dei se number	I. 2: 1 1 2: e of Death / Che ursing Home 5 28d. D 3No 28f. Lc C and place, and du ath occurred at t	3e. Did tob 1 Yes 4a. Was an autops perform Yes 2 Cck only on the secretion (Strip or Town the to the cathe time, did to the cathe t	macco use cont as 2 No and ay and and and and and and and and and and	iribute to the 3 Proba Were autopprior to comdeath? 1 Pres : are (Specify, red	Poay Year a cause of death' bly 4 Unknown sy findings availation of cause 2 No Route Number, tted. the cause(s)

			For	State of M		id / Depa	artment of H	Health and	d Mental Hy		5 31899
			1 - State Registrar			Cei	rtificate of	Death		Reg. No.	
	Physici	an	1. Decedent's Name (First, Middle, L	1 1 1		Du	lin		2. Date of De Month	Day	Yeer 20:34 M
	/Medic		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	or Location of De	eath On	4c. County	
	LAGITIII	اتا د د	University of Mary	land Medica	al Ce	enter	Bal	timor	e		N/A
	Funeral			Sex 7. Ag		last birthday) Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da Sept.	th iy, Year)	Birthplace (State or Foreign Country)
29 %	Director		214-66-9656 Usual Residence of Decedent		49	rrs.			Sept.	3, 1956	Maryland
	nyland how		10a. State 10b. County			y, Town or Lo					10d. Inside City Limits
:	86-1-	cto	Maryland Anne A	rundel	G1	en Bur					1 ☐ Yes 2 ☑ No
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "naturel", or teme 23a or 28e-f ehow event, the Medical Ezerr ner must be notified at	Funeral Director	10e. Street and Number 128 Louise Terra	CO			10f. Zip Code 2106	n		10g. Citizen of W	· ·
	death me 23	era	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.			(Specify Yes or No lerto Rican, etc.)		- American Indian,
	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		1	If Yes, specify Cub 1 ☐ Yes 2 ☐ 1170		ierto Rican, etc.)	Specify:	k, White, etc.
15-0036	filed within 72 hours after Hygiene. Ither then "naturel", or Ite ent, the Medical Exert or	d by	3 Widowed 4 Divorced	Year or Dates:							WILLCE
2	n nat	Completed	15. Decedent's (Specify only highest of	grade completed)	-	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of i	working	16b. Kind of Bu	siness/industry
7 7	d with giene	mo	Elementary/Secondary (0-12)	College (1-4or 9	o+)	1	f Employ			Landsc	aping Company
	be filed ita! Hygi id other event, I	Be	17. Father's Name (First, Middle, La	st)					Name (First, Middle	, Maiden Sumam	
<u> </u>	should ind Men marke umatic	P	Francis 19a. Informant's Name/Relationship	/Tunn Brint	<u></u> р	ulin	an Address (Ctront	Kathle	Pural Route Numbe	- Ch T	Bell
=	2 6 7 6		Leanne M. Dulin								yland 21060
ฃ .	5 5 E 5		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other pla	ce)	Date		City or Town, State
<u>E</u>	Peges ment of I ant: If its ury or o		1 ☐ Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Mem. Pk		/03/05	Annapol:	is Maryland
Baltimore,	permit. Peges Department of I Important: If its eny injury or o		21. Signature of Funeral Service Lic	ensee		M	CCully-P	olyniak	Funeral I	Home, P.	Α.
	ad 2 o d		23a. Pan Lenter the disease, or co	emplications that caused	the deat	3	204 Moun	tain Roa	ad Pasadei	na, Marv	land 21122
₹.8 •	hysician		shock, or heart failure. List on Immediate Cause (Final	ty one cause on each li	ne.			-			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a conseq		ndocard	itis			2 months
	Examiner		Sequentially list conditions,	b. Sept	ic	Shock					
/	lsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):					
	ite be executed ysicien and ne burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):					
	ite be nysicie ne bur	icai		d							
. Q	The law requires thet the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	by Physician/Med	IF FEMALE:	00-1/	.,						
X Q	eath c attend for us	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery oth Day Year
<u>.</u>	thet the de led by the a detached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown			2 0 (0,000)/ _				
ູ່ ກ	uires the signed t id be det	by P	Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use contri	ibute to the cause of death?
or o	w requir been si should I	ted	longue Car	nur					_ 10`	Yes 2□No	3 Probably 4 Unknown
Records,	elaw hasb	Completed							24a. Was autop	osy p	Vere autopsy findings available fior to completion of cause of eath?
			25. Was case referred to medical						1 X Yes	2 No 1	☑Yes 2☐ No
5	ysician: s certific director,	o Be	examiner?	Hospital:	ent 2 🗆	ER/Outpatien	t 3 DOA Ott		Death Check only of g Home 5 Resid		at (Spacific)
D 0	Attending Physician: r death. ector: After this certific by the funeral director.	n: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju	ry	28b. Time of				now injury occurre	
SIO	tendil leath. tor: A the fu	catio	2 Accident investigat 3 Suicide 6 Could not	be			M 1	Yes 2 □ No			
DIVISION	after of At Direc	Certification;	4 Homicide determine		ury - At ho c. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location (Street and Numbe vn. State)	er or Rural Route Number,
	To the Hospitel or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral director.		29a. Certifying	Physician: To the best	of my kno	wledge, death	occurred at the ti	me, date and pla	ace, and due to the	cause(s) and mar	nner as stated.
:	the Ho in 24 the Fu	Medical	one)	eminer: On the basis of and manner st	f examina ated.	ition and/or in					
1	with To	2	29b. Signature and title of certifier				29c. Licens			- 1 1	(Month, Day, Year)
	/		30. Name and address of pirson wh	o completed assess of	loath /lta-	n 22a) /T		435T 158	0.3	9/28/2	1005
	う							ryland.	21201		
	Sta		31. Date filed (Month, Day, Year)	South Greene 33 Högistr	ar's Signa	iture	and a				
*	Registr	ar	OCT 0 3 2	UUJ AMARA	U S	1 100	MIL				

		•	For Stata Registrar		State of Ma	aryland	-	artment of F <i>tificate of</i>		Mental Hy	giene Reg. No.		
	Physici		1. Decedent's Name (Fin	rst, Middle, Last, otte Fra						2. Date of De Month Oct.	Day	2005	3. Time of Satto
)	/Medic Examin		4a. Facility Name (If not LongView N					4b. City, Town, o Manch	ester			County of Death	
	Funeral Director		5. Social Security Number 319-03-938	7 10	7. Ag	e (In yrs. las 98	st birthday) Yrs.	If Under 1 Year Months Days		in (Month Da	th ay, <i>Year)</i> 6, 190	9. Birthpl Count 7 Polar	ace (State or Foreign try)
	Maryland f show	tor	4.4	Baltimo	re		Town or Lo	cation rville				10	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	a with the	ai Directo	10e. Street and Number 1705 Lynnor					10f. Zip Code 21093			10g. Citize	en of What Count	ry?
336	filed within 72 hours after death with the Maryland Hygiene. Wher then "naturel", or llems 23a or 28e-f show ant, It a Medical Evariation must be codified at	by Funerai	11. Marital Status 1 Never Married 3 Xwidowed 4	-	12. Was Decedent Armed Forces? 1 Tyes 2 If If Yes, Give Year or Dates:		1		lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - America Black, White, e	
3500-6121	within 72 hou ene. then "nature is Medical E	Completed	(Specify or (Specify or Elementary/Secondary	Decedent's Edu nly highest grad y (0-12)	cation		(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	vorking		d of Business/Ind	·
_	m = 0 %	To Be Co	17. Father's Name (First) Stefan Roma						18. Mother's N	lame (First, Middle	1	464	
, mary	and 2 should balth and Ment alth and Ment 127 is marked er traumatic e		19a. Informant's Name/I				1705 I	ynncrest	Rd. Lu	Rural Route Numb			Code)
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 □ Burial 2 □ Cre 1 □ Donation 5 □	remation 3 🗆 F		20b. Pla cen Meti	ro Cre	sition (Name of natory or other place ematory C	ct. 3,2		Balt	ation - City or Tov timore,	
Ball	permit. Depart Import any inj		21. Signature of Funeral	& Celly						Chapel P. Mancheste			
,	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	lure. List only o	ne cause on each lie a Due to (or as	ne.	Ctr	er the mode of dyir	-	liac or respiratory a		**	Approximate Interval Between Onset and Death
58760,	ificate be executed physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
O. BOX 68	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 moni 1 ☐ Yes 2 ☐ Ne- 9 ☐ Unknown	iths?	l3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)	,		23	3d. Date of deliver	ry Day Year
rds, P	w requires that the s been signed by th should be detache	þ	Part II. Other significant	t conditions co	ntributing to death b	ut not result	ing in the ur	ndertying cause giv	en in Part I.	1		e contribute to the	e cause of death?
Vital Record	The law ate has b page 2 si	Completed					•					24b. Were autop prior to com death? 1 \(\text{Yes} \)	osy findings available apletion of cause of
\ 	Physician: rthis certific ral director,	Be	25. Was case referred to examiner?		Hospital:			Oth		Death (Check only			
on of	ding Phy h. After this funeral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	N 2	R/Outpatien 8b. Time of Injury	28c. Injur Wor	4 Nursing	Home 5 Resi 28d. Describe			
DIVISION		Certification		Could not be determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To		Number or Rural	Route Number,
	To the Hospital or within 24 hours afte (To the Funeral Dii completely filled in	Medicai ((Check only 2 one)	Medical Exami	sician: To the best ner: On the basis of and manner sta	examinatio		vestigation, in my o	pinion, death oc		date and p	place, and due to	the cause(s)
Ì	To the I	Σ	29b. Signature and title	of certifier	4			29c. Licens	e number	2		signed (Month, E	Day, Year)
	Uj			sen 5	ompleted cause of d	eath (Item 2	23a) (Type,	Print) ansu	6-2	- Yan	fites	s in)
	Sta Registi	-	31. Date filed (Month, Do	T 0 3 20	05 32. Fagistr	ars Signatu	OF A	porti			.54		

			1 - For State Registrar	State of Maryl			ealth and			5 31901
	Physic /Med Exami	cal	1. Decedent's Name (First, Middle, La herry Fair 4a. Facility Name (If not institution, gin St. Aanes Hos			4b. City, Town, or		2. Date of Dea Month Septem	Day Y	Death
	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 8-6-19	9	Birthplace (State or Foreign Country) CAROLIN
	the Maryland r 28a-f ehow notified at	rector	MD . 10b. County N/A	10c	City, Town or Lo			11	0g. Citizen of Wh	10d. Inside City Limits 1
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	leted by Funeral Director	4314 COLBORNE R 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced 15. Decedent's E (Specify only highest gr.	12. Was Decedent Ever i Amped Forces? 1 ZYes 2 No If Yes, Give Year or Dates:	16a. Dece	21229 Was Decedent of His If Yes, specify Cubar 1□ Yes 2☒No dent's Usual Occupa kind of work done d DO NOT use retired) DO NOT use retired	Specify:	pecify Yes or No- o Rican, etc.)	USA	American Indian, White, etc. BLACK
Maryland 212	2 should be filed within and Mental Hygiene. Is marked other than "!	To Be Completed	Elementary/Secondary (0-12) -12- 17. Father's Name (First, Middle, Last JESSIE NORRIS	College (1-4or 5+) -0-	1	BORER	18. Mother's Nan	ne (First, Middle, M		EM STEEL
	1 and 2 should Health and Men em 27 is marke		19a. Informant's Name/Relationship (SANDRA MATIER(N		19b. Mailir 43	ng Address (Street a. 14 COLBORI	nd Number or Ru NE RD . B	ral Route Number ALTIMORE	City or Town, Sta	ate, Zip Code) ND 21229
Baltimore,	permit. Pages 1 a Department of He Important: If item eny injury or oth		20a. Method of Disposition 1 A Burial 2 Cremation 3 C 4 Donation 5 Other (Special Control of Cont	Removal from State (y)	ARRISON HIBNER	FOREST VI	ETERANS s of Facility PH	ILLIPS F	NERAL HO	LLS, MARYLAND
8760,	death certificate be executed e attending physician and dor use as the burial-transit	ilcal Examiner	shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Proford Due to (or as a construction of the	sequence of): red An sequence of):	c shock	k .	Aneury		Approximate Interval Between Onser and Death Chrs Chrs Chrs
P.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
Division of Vital Records, P	law requires as been sign 2 should be	Completed by Pl	Part II. Other significant conditions of Hypertension, Wo myocard	ontributing to death but not of Coronary I Lial infarct	Artery	derlying cause given	n in Part I.	1 ☐ Ye. 24a. Was an autopsy	s 2 No 3	e autopsy findings available to completion of cause of
Vital	ysician: The lis certificate he director, page	Be	25. Was case referred to medical examiner?	Hospital:				h (Check only one	ØNo 1□	Yes 20 No
sion of	Attending Physician: It death. Sector: After this certific: by the funeral director.	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Work?	at i	ome 5 Resider 28d. Describe how	nce 6 Other (Specify)
Divi	in Diffe		4 Homicide determined	building, etc. (Spe	control death	occurred at the time	date and place	City or Town,	State)	r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Exemple 29b. Signature and title of certifier	niner: On the basis of examinand manner stated.	ination and/or inv	estigation, in my opin	nion, death occur	red at the time, da	te and place, and	due to the cause(s)
14	14		30. Name and address of person who stace Stephens	completed cause of death (II	em 23a) (Type, F	Print) Bulli	006 mou H	D 21229	9/29/0	
	Sta Registr	121	31. Date filed (Month, Day, Year) 20	05 32 egistrar's Sig	nature	all!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. NG. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician TREER 10:45 AM HAN DEPT 30 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHRIST IMORE GIL HOSPICE If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. Jast birthday) **Funeral** Days Months Min. Hours 1**⊠**M 2□F -44-4349 Yrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MARVLAND Directo 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code HERRYCREST ROAD or Items 23a Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XYes 2 □ No fYes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 end 2 should be filed within 7 nent of Heelth and Mental Hygiene. Int: if item 27 is marked other then " al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING CO. DUPERVISOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ULIVER 4LICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2:
Department of Heelth a important: if item 27 is any injury or other trau SISTER STEND BALTO, MD. 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date . Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CROWASVILLE GME 10-06-05 CROWNSVILLE 4 Donation 5 Other (Specify) 21. Signal of Funeral Service Licensee 22. Name and Address of Facility BROWN 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death OROPHARYNGEAH Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) ettending physiclen P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, page 2 should be ANCER 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 Yes 2 No death. filled in by the fu investigation 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire ö To the Hospital 115 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R Faulkner MP rendall' , Charles Street 32. Projistra/s Signature 31. Date filed (Month, Day, Year)

OCT 0 3

DHMH 17 Rev 1/2001

State

Registrar

3

2005

EER

			For State	State of Ma	ryland /	Depa	rtment of Heatificate of De	alth and M	fental Hygi	ene 20	0.5	31903
			Registrar 1. Decedent's Name (First, Middle,			Cer	ilicate of De	eau i	2. Date of Death	g. No.		3. Time of Death
	Physicia	an		2401/		Lina	ahoa-Enn	c	Month	Day Y	'ear	
-	/Medic		Lizzie 4a. Facility Name (If not institution,	give street and number)		nu	ghes-Epp 4b. City, Town, or Lo		0.5	4c. County of		11°25p [™]
	Examin	er	11902 Tarrago		it G		Reiste				timo	re
Ī	Funeral Director		5. Social Security Number 246-58-9887	3. Sex 7. Age	(In yrs. last I	birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08 26		Birthplac Country	e (State or Foreign) C
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation				10d	Inside City Limits
	daryi f eho	ō	MD Balti	more	Re	iste	rstown					1 ☐ Yes 2 ☐ X No
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	10e. Street and Number	MOLC			10f. Zip Code		10	g. Citizen of Wh	at Country	?
	3a ol	0	11902 Tarrago	n Road Uni	it G		2113	6		U.S	.A.	
	deatl	ner	11. Marital Status	12, Was Decedent E Armed Forces?		13. W	as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Sp	ecify Yes or No-		American White, etc.	
0	or its	F	1 Never Married 2 Marrie Marrie				Yes 2X No		rticali, etc.)	Specify:		
0000	urai',	d by	3 Widowed 4 Divorced	Year or Dates:							Bla	
<u> </u>	"natu	ete	15. Decedent's (Specify only highest	Education grade completed)	16	Sa. Deced	ent's Usual Occupation and of work done during ONOT use retired)	on ing most of work	ing 1	6b. Kind of Busi	ness/Indus	stry
7	I be filed within 72 hours efter death with the Marylan and Hygiene. All Hygiene. Al	Completed	Elementary/Secondary (0-12) 12th grade	Cotlege (1-4or 5-	+) !		mssRepre			Insura	nce	Company
7 D	Hygi Hygi ther ant, 1	ပိ	17. Father's Name (First, Middle, La			0141			e (First, Middle, M			
and	d be ental ked c	To Be	Nello Hughes				N	obie T	uck			
<u></u>	2 should by and Menta is marked	-	19a. Informant's Name/Relationship	p (Type, Print)	1	9b. Mailing	Address (Street and			City or Town, St	ate, Zip Co	ode)
Ž	alith a		Hodges Epps J	rHusband	a E	1190	2 Tarrag	on Roa	d Unit	G, Rei	ster	stown, M
ē,	of Hear item	1	20a. Method of Disposition				ition (Name of atory or other place)			0c. Location - Ci		
Baitimor	permit. Pages of Department of Hamportant: If Ite eny injury or of ODE.		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Forest	Vet. 9	/30/05	Owings	Mil	ls, Md
= 0	permit. Departn Imports eny inju	l	21. Signature of Funeral Service Li	sensee			Name and Address o					
מ	88 = 58		1 Jala	March	_	43	00 Wabas	h Ave,	Baltim	ore, M	.d 2	1215
<u>)</u>	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused nly one cause onlead nlin	140	MC			or respiratory arre		2y 6	pproximate terval Between nset and Death
	Examiner		spromo september en estado est	Due to (or as a	consequenc	e 01).						
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequenc	e of):						-
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	that initiated events	c								
,00	be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence	e of):						
	ate b hysic the bu	lical	ll .	d								
200	certifica rding ph ise as th	Completed by Physician/Med	IF FEMALE:	000 16	-1							
XOQ	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 🗌 Fetal dea		Ectopic pregnancy Other <i>(specify)</i>			23d. Date of Month	,	ıy Year
5	he de the d	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ume or death	5□	Other (specify)					
ŗ.	The law requires that the death sie hes been signed by the atter page 2 should be detached for u	F.	Part II. Other significant condition	s contributing to death bu	ıt not resulting	g in the un	derlying cause given	in Part I.	23e. Did toba	acco use contrib	ute to the o	cause of death?
S	uires sign ld be	d b							1 ☐ Yes	s 2□No 3	☐ Probabl	y 4 Unknown
cords	w req	ete							24a. Was an	24h We	re autonsy	/ lindings available
Ē	he la e hes ige 2	E C							autopsy	ed? pric	or to compleath?	letion of cause of
	ificete or, pa	CC	25. Was case referred to medical					6 Place of Deat	1 Yes 2 h (Check only one		Yes 2	INO
>	Attending Physician: r death. ector: After this certific by the funeral director.	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2□ER/	Outpatient	Other		me 5 Resider		(Specify)	
5	g Phy er this	-	27. Manner of Death	28a. Date of Injury		. Time of	28c. Injury at Work?		28d. Describe how			
	ath. r: Aft	atlo	1 ØNatural 5 ☐ Pending 2 ☐ Accident investiga	ation	7047)	Injury		s 2 No				
<u> </u>	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		iry - At home,	larm, stre	et, factory, office		281. Location (Str. City or Town,	eet and Number State)	or Rural R	oute Number,
5	rs afte al Dire	Cer										
	d hou	cal	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the best o xeminer: On the basis of	of my knowled	lge, death and/or inv	occurred at the time,	date and place,	and due to the car	use(s) and mann	er as state	ed. e cause(s)
	To the Hospitel or Attending Physician: The law within 24 bours after death. To the Funeral Director: To the Funeral Director, page 2 completely filled in by the funeral director, page 2.	Medical	29b. Signature and title of certifier.	and manner stat	ted.		29c. License n			d. Date signed (
	2 × 0		and title of certifier	MITTO	X 1	0	N D	500	10 6		C1 _	7
/	10		20 100	Junua	TOO		177	\mathcal{I}	10	1- 6		4
			30. Name and address of person w Flavio Krut	er 5	55 S	Type, F		-St. 1	Nestmi	nster.	MD	21157
5-	Sta Registr		31. Date filed (Month, Day, Year)		ur's Signature	L	1					

ORIGINA

		•	For State Registrar	State of M	-	partment of F ertificate of		Re	2005	31904
	Physicia	n	1. Decedent's Name (First, Middle, La.				7	2. Date of Deat	DayYear	
	/Medic	al	Delores		ancis_		r Location of Death	Sept.	4c. County of De	
4	Examin	er	4a. Facility Name (If not institution, giv			Baltin			40. Obuilty of Do	aur
	Funeral		Levindale Nurs 5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthd			8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		219-26-1760	□M 2 X)F	68 Yrs	Months Days	Hours Min.	01 1	t t	MD
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Manyla f sho	ō	MD NA		Balt	imore				XXYes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?
	th with		4325 Shamrock	Ave Apt	#2		1206		U.S.	
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 1	Was Decedent of H If Yes, specify Cub:	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Vivorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	ľνο	1 ☐ Yes 2 💢 No	Specify:		Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or tlems 23e or 28e-f show the Medical Examinat Iroust ke molified at	ted	15. Decedent's E	ducation	16a. De	cedent's Usual Occup ive kind of work done	pation		16b. Kind of Busines	s/Industry
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	if	e. DO NDT use retire	d)	w.g		
	filed withi Hygiene. other ther ent, the N		12th grade 17. Father's Name (First, Middle, Last	<u>na</u>		Disable		ne (First, Middle, M	Disab	Ted
and	ould be fi Mental H arked ot: atic ever	Be C	Henry Adams				Francis		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Maryland	& PEE	2	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street	and Number or Ru	ral Route Number	City or Town, State	, Zip Code)
Ž	and 2 ralth a 27 is		William Locket	t-Son		25 Shamr				
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from State	1 1	sposition (Name of crematory or other pla			20c. Location - City of	
ij	Pag tment tant:		* 4 □ Donation 5 □ Other (Special	(y)	Metro	Crematory		30/05	Baltimo	re, Md
Bal	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau		21. Signatule Funeral Service Lice			22. Name and Addre March F/I 4300 Waba	H West	Dol+i	mara Md	21215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	one cause on each	ine.					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to or as	a consequence of):	0 1				7-212-3
	Examiner		Sequentially list conditions.	b. End		Renal!	Visens	<		
	ed isit	lne	Sequentially list conditions, if any, leading to immediate cause, enter underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
760	ate be executed hysician and the burial-transit	cal		d						_
89	certificat nding phy use as th		IF FEMALE:							
Вох	death certifical le attending phy ed for use as th	lan/	23b. Was decedent pregnant		2 Fetal death	3 □Ectopic pregnanc	у		23d. Date of d Month	lelivery Day Year
0.	he dea	Physician/Med	in the past 12 ∩onths? 1 □ Yes 2 □ No 9 □ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	5 Other (specify)				
ط	res that the de signed by the a be detached t		Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cause gr	ven in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
Records,		ed by						1 □ Ye	es 2□No 3□	Probably 4 Unknown
900	aw S d	Completed						24a. Was a autops	n 24b. Were	autopsy findings available o completion of cause of
E	Th ate pag	Com						perform 1 ☐ Yes	ned? death No 1 □ Y	?
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	han	th (Check only on		
of	Phys this al dii	- 10	1 Yes 2 No	28a. Da e of In	ury 28b. Tim	ILIBITE 3 DOA	4 Nulskig Fi		ence 6 Other (S) ow injury occurred	pecify)
lon	Attending In death. ector: After by the funer	atlon	Natural 5 Pending	(Month, D	a <i>y Year)</i> Inju		rk?]Yes 2 □ No			
Division of	ii or Attendii after death. I Director: Al d in by the fu	Certification:	3 Suicide 6 Could not determined	28e. Place of In	njury - At home, farm	, street, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
Ö	ital or irs afte rai Dir led in	Cer		1						
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in '	edical			of examination and/o	eath occurred at the to or investigation, in my				
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (Mo	nth, Day, Year)
	- s + ō	1	1 Sula 11		C 30	- 0	23767	/ !	Septem	25,500
1	1/2		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	rpe, Print)	1.1	1	PI	21
	V		Vebra /lershe	merni	243	W. Del	udere,	the.	Dalto 1	N 21215
	St Regist		31. Date filed (Month, Day, Year) OCT 0 3	2005 32. Hegy	trar's Signature	for N.				
DE	IMH 17 Rev 1/2	200	00100	2007	MARI SS	PERENTE				

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

EPTEMBER 28,

-064	98			1 icuse	State of	Mandar	od / Don	artmon	t of H	aalth s	and Ma	ental Hyc	iene	.09.5.0.		
n		•	For Unpend	Item 2	23a,27,2	Ba-f pe	r me G	848 1	0-3- e of L	05 ta Death	is	Bulleting	lea No.	2005	3 1	906
.3			Registrar 1. Decedent's Name (Fi					7 (777 (787)				2. Date of Dea	th		3. Time of	Death
	Physicia /Medic	_	Kenneth	1	Da	avid		Hof	fman		S	Month Septembe	er 2	3, 2005	9:17	A M
	Examin	er	4a. Facility Name (If not	_				,		Location of	of Death	-	4c. 0	County of Death		
			University			dical (-	altin		24 Hrs.	9 Date of Birth		N/A	nlane (State o	or Foreign
2	Funeral Director		5. Social Security Numb		Sex 1 ☑ M 2 ☐ F	7. Age (III yrs.	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Aug. 2	Year) 1.19	58 Ma	place (State on try) ryland	ii i Greigh
3	16		Usuel Residence of Dec	cedent								nug		70 1		
	ehow	_	10a. State 10	b. County			ty, Town or L								10d. Inside C 1 ☐ Yes	
	death with the Maryland ms 23s or 28s-f ehow rinust be notified at	Funeral Director	Maryland 10e. Street and Number		rundel	G1	en Bur	nie 10f. Zip	Code				10g. Citiz	en of What Co	intry?	
	3a or	2			nnapolis	s Blvd.			2106	1				U.S.A.		
	death	nera	11. Marital Status	inore ii		dent Ever in L					igin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Amer Black, White		
36	or Ite	by Fu	1 Never Married	. —	1 ☐ Yes If Yes, Giv	2 No		1 🗆 Yes	_	Specify:				Specify:	White	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Hauth and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. The Medical Exartizer must be notified at		3 Widowed 4 2	Decedent's E	Year or Da	ates:	16a. Dece	dent's Usua	al Occupa	ation		1	16b. Kin	d of Business/l		
215	within 72 ene. then "na he Medic	plet		only highest gr	ade completed) College (1	-4or 5+)	(Give	kind of wo DO NOT us	rk done o se retired	during mos ()	t of workin	ng .				
21	e filed within al Hygiene. I other then 'vent, the we	Completed	12	- 1	N/A			Ro	ofer					tractin	g Comp	any
pu	be file	Be	17. Father's Name (Firs	t, Middle, Las	t)							(First, Middle,				
r ∑la	2 should be and Mental le marked o	은	Gordon 19a. Informant's Name	/Relationship	(Type Print)	Hoi	fman	ing Address	(Street a		ricia er or Rura		A.	Town, State, Z	anahan ip Code)	
Z	ith an 27 le r		Patricia A.		N045	er)		•						and 211		
5	s 1 end 2 of Health Item 27 i		20a. Method of Disposit	tion	5-2744	20b.	Place of Disp cemetery, cre	osition (Nar	ne of		D	ate	20c. Loc	cation - City or	own, State	
Ë	8 = 5		1 ∰ Surial 2 □ C 4 □ Donation 5 □			STATE	dar Hi				10/1	/05	Bro	oklyn M	arylan	.d
Baltimore,	permit. Pa Departmen Importent: any Injury once.		21. Signature of Funer	al Service Lice	ensee		Ŋ	2. Name an	y-Po	lynia	k Fu	neral H	ome,	P.A.		
	20 E E a		23a. Part1. 5 er the c	w.T.	li Clins	succed the dea	- 3	204 M	ount	ain I	toad 1	Pasaden	a. M	aryland	21122 Approxima	
			shock, or heart fa	titure. List only	y one cause on e	ach line.									Interval Bei Onset and	tween
	Physician /Medical	K 14	disease or condition resulting in death)		a	or as a conse		ine ar	ia Co	ocain	e) 11	toxicat	LTOII			
0	Examiner		Commentative line and dist		b											
	p #	ner	Sequentially list conditi if any, leading to imme cause. Enter Underlyin Cause (Disease or inju	idiate	Due to	(or as a conse	quence of):									
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	_	c	(or as a conse	quence of):									
760,		calE			ं त		,									
687	w ~ w				_ d											
Box	leath certificate attending phy. I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pre		23c. If yes, out	come of pregr		□Ectopic p	regnancy	,			2	3d. Date of deli Month		Year
Э. В	e deat he att	sicis	in the past 12 mo			ant at time of		Other (st						Month	Day	T Gal
P.0	het the	Phy	9 Unknown Part II. Other significat	nt conditions	contributing to d	eath but not re	sulting in the	underlying (ause giv	en in Part	l,	23e. Did to	obacco us	se contribute to	the cause of	death?
ds,	signe d be c	d by	art ii. Ontor significa		00111110211119100				3			1 🗆 Y	es 2	XNo 3□Pr	obably 4 🗆	Unknown
Division of Vital Records,	w requ	Completed						-				24a. Was		24b. Were au	topsy findings	available
Be	The la te hes age 2	dmo											rmed? 2 \Begin{array}{c} No	prior to d d al. ? 1 X es	ompletion of a	cause of
ital	ian: Trifica	BeC	25. Was case referred examiner?	to medical	(10)					26. Plac	e of Death	Check only o				
> _	hysic his ce	To E	1X Yes 2 No				XER/Outpatie			4 🗆 14				Other (Spec		
n c	ling P		27. Manner of Death 1 □ Natural	5 Pending	Found	of Injury th, Day Year)	Found	of :	28c. Injur Wor	yat k? Yes 2.5op		28d. Describe h	now injury	occurred		unk
isio	death death ctor: y the	flcat	0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 -	investigati 6 X Could not determine	be 28e Place	-05 of Injury · At	8:35 home, farm, s	_A		X	-	28f. Location (S	Street and	1301_W	ral Route Nur	nber,
ο	affor affor Dire	Certification:	4 Homicide	Getermine	build	ing, etc. <i>(Spec</i> nd: woo	cify)		-		1	Baltimo:	vn, State) re C	1301 W ity, Ma	. Oste ryland	nd St.
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1[(Check only 26)	Certifying F	Physician: To the aminer: On the b				at the tir	ne, date a	nd place, a	and due to the	cause(s)	and manner as	stated. to the cause(s)
	ths H iin 24 the Fi	fedical	0/16)	1	and man	ner stated.	4			e number				e signed (Monti		
	or too	Σ	29b. Signature and title	3 of Certifier	de		1	29		C.M.E	•			tember 2	-)5
	7		30. Name and address	of person un	o completed cau	e of death (Its	em 23a) (Tune	e. Print)					-			
	3		Susan R. I		\)			Stra	eet	Balti	imore. 1	Marv	land 21	201	
**		ate	31. Date filed (Month,	Day, Year)	32. F	Registrar's Sigi	nature	-		,						
# (Regist	rar	0	CT 0 3	2005	Outres .	16 1	marke	9							

DHMH 17 Rev 1/2001

			1 10030	State of Mai	adond /	Donart	mont of L	loalth and	Mental Hy	raione	912.0.	
		4	For State	State of Mai	yland /		icate of		и менан пу	Reg. No.	05	31907
			Registrar 1. Decedent's Name (First, Middle, La	st)		007111	10010 07		2. Date of De	ath		3. Time of Death
	Physicia /Medic		GENEVIEVE	JONES					Septem	iber 27	2005	0813 AM
1	Examin		4a. Facility Name (If not institution, give	e street and number)		4t	Λ.	Location of De	eath		inty of Death	
1			MERCY MEDIC 5. Social Security Number 6.5	AL CONT	(In yrs. last	hirthday) If	Under 1 Year	MORE If Under 24 H	rs. 8 Date of Bi		N/A	place (State or Foreign
	Funeral Director			C	75		onths Days		in. (Month, D		Cou	abama
	D.		Usual Residence of Decedent							-		10d. Inside City Limits
	ahow	'nΜ	10a. State 10b. County [aryland N/A			own or Locati altime						1X Yes 2 No
	the M	recto	10e. Street and Number			1	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do they than "neturel", or items 23a or 28a-f ahow do they than "neturel", or items 23a or 28a-f ahow event, the Medical Examiner must be inclified at	a D	Iaryland N/A 10e. Street and Number 3500 Esnor Roa 11. Marital Status 1 Never Married 2 Married	ad Apt. 4	103		21218	3		U	SA	
	ems ems	Iner	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was	Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)		Race - Ameri Black, White,	etc.
9	72 hours after neturel', or ite dical Examine	by F.	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:)	10	Yes 2ૐNo	Specify:		Spe	ecify: Bl	ack
2-003g	2 hour		15. Decedent's E	ducation	1	6a. Decedent	's Usual Occup	ation	wasting		of Business/Ir	
2	within 7; ene. than "n	ompleted	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)			during most of		į.		curity
N	led wi tygien her th	O	17. Father's Name (First, Middle, Lasi	4 Years	P	Admini	strat		sistant Name (First, Middle			ation
and	d be fi	o Be	Rance Grace	,					ia Cook			
<u> </u>	shoul nd Me mark	2	19a. Informant's Name/Relationship	Type, Print)		19b. Mailing A	ddress (Street	a <i>nd Number</i> or	Rural Route Numi	per, City or To	wn, State, Zij	Code)
, Mal	and 2		Elarn Jeffers	on/ Siste:				by Str	eet Bal			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other treumetic ev QDC8.		20a. Method of Disposition	☐Removal from State	20b. Place	of Disposition of Dis	on (Name of ory or other place or i = 1	Park10	/4/05		on - City or T awn .	own, State Maryland
	it. Pa rtmen rtant: njury		*4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		VIII	22 N		es of Facility	hatman-	-	•	eral Home
g	Depa Impo any i		Peru //in	AS.		52	10 Rei	sterst	own Rd	Balti	more,	Md21215
	<u> </u>	4	23a. P. 1. Enter the dis ase, or con	pplications that caused to	he death. [Do not enter t	he mode of dyir	ng, such as care	diac or respiratory	arrest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition			ANIAL	HEMO	RRHAG	6			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):						
	*	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		ce of):	1010					
6	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
/60,	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a	consequen	ce of):						
∞	physic physic the b	dlcal	•	d								
Pox 6	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						23d.	Date of deliv	rery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ■ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			topic pregnanc ther (s <i>pecify</i>) _	<i>y</i>			Month	Day Year
J Ö	requires that the leen signed by th hould be detache	Phys	9 Unknown Part II. Other significant conditions		not ropultin	e in the under	rhing agus an	on in Part I	23e Did	tobacco use	contribute to	the cause of death?
g Q	ires thal signed b	d by	Partii. Ditier significant conditions	contributing to death but	THOU TESUILII	ig in the unde	riyirig cause gir	ren in raiti.		Yes 2 N		
ecords,		Completed							24a. Wa	s an 2	4b. Were aut	opsy findings available
r	The law ate has b	omp							— auto perf 1 ☐ Yes	ormed?	prior to co death? 1 Yes	ompletion of cause of 2 No
Vital		Be C	25. Was case reterred to medical examiner?						Death (Check only	_		
of V	Physician: rthis certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 Inpatien			3LI DOA		g Home 5 ☐ Res			fy)
5	ling After fune	lon:	27. Manner of Death 1. Natural 5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury	28c. Inju	nyat nk? Yes 2.∐No	28d. Describe	now injury oc	curred	
Division	tten deat stor: the	ifica	3 Suicide 6 Could not	be 28e. Place of Injur	ry - At home	, larm, street				(Street and Nown, State)	umber or Rui	al Route Number.
	tal or A	Certification:	4 Homicide determine	building, etc.	(Specily)				Ony or 10	,wii, State)		
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I		(Check only 2 Medicel Exa	hysicien: To the best of miner: On the basis of	examination							
	To the hwithin 24	Medical	29b. Signature and title of certifier	and manner stat	ed.		29c. Licens	se number		29d. Date si	gned (Month	Day, Year)
	⊢ 3 ⊢ ŏ		ROMADIAN	Bonn	MO		12	611		Septou	nben!	27 2005
	10		30. Name and address of person who		ath (Item 23	Ba) (Type, Pri				-710		1
	V		Stephanie Boy 31. Date liled (Month, Day, Year)	UM MD	r's Sianatur	9.4						
8	Sta Registi		OCT 0 3 2005	32. Registra	A A	bartes						
	3		AA1 0 0 F000	1000	-							

			1- For Amend Item 1 State of Maryland / Dep Registrer 1 per Dr., G848, 10/03	artment of Health and Men 05dbb hilicate of Death	tal Hygiene Reg. Nd	2005 (31908
	·		1. Decedent's Name (First, Middle, Last) Charles W. Kiel		Date of Death		3. Time of Death
	Physicia /Medic		CHARLES W KIEL, SR.		9 17	2005	5:45 PM
	Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death	
52%	3		UNIVOUSIN OF MANERALY MEDICAL CENTER	Britan With		altimore C	
	- Funeral		5. Social Security Number 388-26-0850 6. Sex 1 \(\mathbb{N} \) M 2 \(\text{T} \) F 77 Yrs.	Months Days Hours Min. (#	Date of Birth Month, Day, Year) D-13-1927	Country	e (State or Foreign)
le T	Director		Usual Residence of Decedent	10	7-13-1327	/ MD	
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d	Inside City Limits
	a-f s	to	MD Anne Arundel Odento	on			1 Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Cit	izen of What Country	?
	23a		701 Linden Grove Place	21113		U.S.A.	
	teme	Funeral	Amed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	 Race - American Black, White, etc. 	
36	i within 72 hours after death with the Maryland liene. r then "naturel", or fleme 23a or 28a-f show The Medical Examinat must be notified at	by F	1 Never Married 2XXMarried 1X/Yes 2 No 1940— 1Yes, Give 1Year or Dates: 1946	1 ☐ Yes 2 🏋 No Specify:		Specify: Whi	te
8	ture cal E	ed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. K	ind of Business/Indus	stry
215	within 72 ene. then *net	pie	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	s kind of work done during most of working DO NOT use retired)			
21	giene gran	Completed		ıck Driver		rucking	
Maryland 21215-0036	tal Hygie d other event, II	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First	st, Middle, Maiden	Sumame)	
yla	D 2 2 0	၉	Oscar Kiel, Sr.	Unknown			
Mar	~ ~ ~		1.121	ing Address (Street and Number or Rural Rou	-		ode)
	and teel		20a Method of Disposition 20b. Place of Disp	Linden Grove Place: O		MD 21113 ocation - City or Town	, State
Baltimore,	permit. Pages I Department of H important: If ite any Injury or ot once.		1 YBurial 2 Cremation 3 Removal from State cemetery, cre	matory or other place) pherd Cemetery 9-21-2		,	
Ē	artme artme ortani injury			2. Name and Address of Facility Sing1			
Ba	permit. Departr imports any inji			Second Ave SW; Glen			IA
AL)	N.		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			A	pproximate terval Between
	Physician	(A Committee of the comm	1130514			nset and Death
1	/Medical		resulting in death) a. Due to (or as a consequence of):	- 7,3			- /
	Examiner		Sequentially list conditions, b. Ms contact	SCHOMIA			3 Hus
	D #	Iner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury				1
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			10	YEMIS
8760,	cate be executed physicien and the burial-transit	<u>e</u>	Due to (or as a consequence or).				
387	physicate s the	dical	d				
9 xc	eath certific attending p i for use as	Z/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Вох	death a atter	Physician/Me	in the past 12 months? 4 Pregnant at time of death	□Ectopic pregnancy □ Other (specify)		Month Da	ay Year
0	that the de led by the a	hys	9 Unknown				
s, P	Se 75 0	by P	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco t	use contribute to the	
ord	w require been sig	ted	coronary artery disease		1 ☐ Yes 2	□ No 3 SProbab	ly 4 ∐Unknown
ec	e fawr has be ge 2 sh	ple	, ,		24a. Was an autopsy		findings available letion of cause of
<u> </u>		Completed		1	performed? 1 ☐ Yes 2 ☐ No	death? 1 ☐ Yes 2[□No
Vital Records,	Physicien: The this certificate hiral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death Ch	eck only one		
of	Physi this c	၉	1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of Death		5 Residence Describe how injur		
E C	After funer	io	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 28d. Work? M 1 ☐ Yes 2 ☐ No	Describe now injur	ly occurred	
Division	or Attending after death. Director: After in by the fune	fical	3 Suicide 6 Could not be 28e, Place of friury - At home, farm, s		ocation (Street ar	nd Number or Rural R	oute Number,
Ö	after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer		29a. Certifier 1 (A Certifying Physicien: To the best of my knowledge, dea				
	n 24 n 24 he Fu	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at	the time, date and	d place, and due to th	e cause(s)
	To t To t	Σ	29b. Signature and little of certifier	29c. License number	29d. Da	te signed (Month, Da	y, Year)
			SING MOGINIE		9/	117/05	
1	(Q)		30. Name and address of person who completed cause of death (Item 23a) (Type 22 S. Grape St. Ba.)	linure, n.D 210	212/		
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	(110) () (11) 010	0 (
	Sta Regista		OCT 0 3 2005	les de la company de la compan			

DHMH 17 Rev 1/2001

ORIGINAL

The property serve

	1	For State Registrar	State of Maryland / Dep Ce	artment of Health and <i>rtificate of Death</i>	, , ,	ene g. N2 0 0 5 3 1 9 0 9
Physicia		1. Decedent's Name (First, Middle, Las	" Kratz-Wrat	chford	2. Date of Death Month September	Day Yeer 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Der Baltimore		4c. County of Deeth
Funeral Director		5. Social Security Number 6. Sec. 218-60-9526				Year) 9. Birthplace (State or Fore
8a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Anne Anne Anne Anne Anne Anne An	10c. City, Town or L	Glen Burnie		10d. Inside City Lim 1 ☐ Yes 2 ☒
23a or 2	ai Dire	10e. Street and Number 7972 Oakwood Road	1	10f. Zip Code 2106		g. Citizen of What Country? United States
permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Dispartment of Health and Mental Hygiene. Dispartment of Health and Mental Hygiene. Introcrant: If time IZ 1s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2€ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2X No Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
vifnin 72 no ne. han "natur e Msolcal	mpieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give life.	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	6b. Kind of Business/Industry
ouid be filed with Mental Hygiene arked other tha atic event, the N	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Earl Grammer, Sr.			ame (First, Middle, Ma	City Financial aiden Surname)
and 2 should salth and Men n 27 Is marke ler traumatic		19a. Informant's Name/Relationship (7) Mr. Richard W. Wra		ng Address (Street and Number or N 2 Oakwood Road G		
Pages 1 and nent of Health ant: If item 27 ary or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Cther (Specify,	nemovariiom state i	osition (Name of matory or other place) Hill Mem. Gdns. 1		Oc. Location - City or Town, State Middle River, MD
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	ine 2	2. Name and Address of Facility Ouda-Ruck Funeral 1922 Wise Ave. 17	. Home of I	Dundalk, Inc.
Physician /Medical Examiner		23a. at 1. Enter the disease comp shock, or heart failure list only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the death. Do not en one cause on each line. a	er the mode of dying, such as cardi	ac or respiratory arres	Approximate Interval Between Criset and Death
	cai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
The raw requires that the bean certificate be executed at the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE:		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires ma been signed I should be det	by	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death?
9 6	plet				24a. Was an autopsy performe	24b. Were autopsy findings availa prior to completion of cause death?
e has b	E				1	No 1 ☐ Yes 2 ☑ No
ysician: is certifica director, I	To Be Completed	25. Was case referred to medical examiner?	Hospital: 1 Thipatient 2 ER/Outpatien	O++	eath (Check only one)	
or Attending Frigstolan: after death. Director: After this certifical in by the funeral director, i	To Be	examiner?	Hospital: 1 Dispatient 2 EP/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, str building, etc. (Specify)	of 3 DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	eath (Check only one) Home 5 Residence 28d. Describe how	ce 6 Other (Specify) injury occurred et and Number or Rural Route Number.
nospina or Arenium prinsican. 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, i	Certification: To Be	examiner? 1 Yes No 27. Mann f Death 1 atural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physics	28a. Date of Injury 28a. Place of Injury 28b. Place of Injury - At home, farm, str	ott 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No eet, factory, office	Home 5 Residence 28d. Describe how 28f. Location (Streen City or Town.)	ce 6 Other (Specify) injury occurred et and Number or Rural Route Number, State)
of Attending ritystolain: after death. Director: After this certifical in by the funeral director, I	To Be	examiner? 1	28a. Date of Injury 28a. Place of Injury - At home, farm, str building, etc. (Specify) sicien: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	of 3 DOA Other: 4 Nursing A Nursing Other: 4	eath (Check only one) Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, see, and due to the causurred at the time, date	ce 6 Other (Specify) injury occurred et and Number or Rural Route Number, State)

			For State	State of Maryl	•	rtment of H			2005	21010
	Physici	an	1. Decedent's Name (First, Middle, Last) ALE XANDER	LUBENO		inicate of L	2	P. Date of Death Month Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give NORTHWEST H	SPITAL (ENTER		Location of Death	40	County of Death	
	Funeral Director		5. Social Security Number 6. Sec	01	yrs. last birthday). 4 9 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Year, 1 - 4 - 195	Cour	elece (State or Foreign htry)
	yland		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	cation			т-	0d. Inside City Limits
	the Mar	Director	MD Baltin	iore	Pikesvi	10f. Zip Code		10a. Ci	itizen of What Cour	1 🗆 Yes 2 No
	238 or	ralDI	711 Sudbrook Ro			2120			JSA	
920	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "naturel", or Iteme 23a or 28a-f ehow avent, the Medical Examinar must be inclified at avent, the Medical Examinar must be inclified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		V	spanic Origin? (Specin, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White.	etc.
Baltimore, Maryland 21215-0036	in 72 ho "natur edicel	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired.	uring most of working	16b. h	Kind of Business/In	dustry
212	e filed within at Hygiene. I other then "		Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		rophysi	cist	Hub	ble Spa	ce G i r.
land	uld be fil Aental H rked otl tic sven	To Be	17. Father's Name (First, Middle, Last) Bodo Lubenow				18. Mother's Name (n Sumame)	
Mary	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumatic	1 3	19a. Informant's Name/Relationship (Ty Bodo Lubenow	pe, Print)	1		Rd., Pi			•
ore,	es 1 an of Heal if item 2 or other		20a. Method of Disposition 1 □ Burial 2 N Cremation 3 □ P	1	b. Place of Dispos		Da		ocation - City or To	
Ħ	iit. Pa artmen ortant: injury i.		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Server Licens		outh Ca	rroll C	rem. 9-3	0-05 Wi	infield,	MD Balto. Co.
Ba	Peri Peper Find Popur		month	VN/N 6=	92	00 Libe	rty Rd.,	Randall		MD 21133
	Physician		23a. Fart 1. Enter the disease or comples shock, or heart failure. List only or Immediate Cause (Final disease or condition	PANCRE			indema	respiratory arrest.		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con		Of the				
	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of).					
30,	icate be executed physicien end s the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
68760,	tificate b ig physic as the b	ledical		l						
P.O. Box	thet the death certificate be executed ed by the attending physicien end deteched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
rds, P.	law requires thet theses been signed by 2 should be detect	<u>۾</u>	Part II. Other significant conditions con	ntributing to death but not	resulting in the un	derlying cause give	n in Part I.	23e. Did tobacco	use contribute to the	10
Division of Vital Records,	The ate h	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2	death?	psy findings available impletion of cause of 2 No
fVit	di is	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	lospital: 1 Anpatient	2 ☐ ER/Outpatien	3□ DOA Othe	26. Place of Death (Check only one) 5 🗀 Residence	6 ☐Other (Specif	y)
ion o	Attending Pt r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work M 1 🗆	at 28 ? ′es 2 □ No	d. Describe how inju	iry occurred	
Divis	of or Attended efter death Director:	Certification:	3 Suicide 5 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre	et, factory, office	28	f. Location (Street a City or Town, Stat		I Route Number.
'	To the Hospital or Attending Phwithin 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 2 Medical Exami	ner: On the best of my ner: On the basis of exam and manner stated.	knowledge, Jeath nination and/or inv	oncurred at the time estigation, in my op	a data and place, an inion, death occurred	d due to the nauce(e l at the time, date an	t) and mark ar as st od place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and the of certifier	PHUSICA		,	2723	SEP1E	ate signed (Month, でのみとれ 。 え	9 2005
1	1		30. Name and odress of person who co	mpleted cause of death	(Item 23a) (Type, I	Print) NORTH	OLD COU	TOSPITAL NT ROAT	CEN	TER. Dan33.
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's S		also				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rodney Draper Long Sept 29 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year if Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 → M 2 □ F Hours 193 30 9273 Yrs. Director 66 Jan 31, 1939 | Pennsylvania Usual Residence of Decedent death with the Maryland 10b County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XX Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 12819 Glynit Road natural, or Items 23a 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1956
1 10 yes 2 No 14 yes, Give 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc.
African American Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hyglene. Int: If item 27 te marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XVX Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Techinician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Long Annie Draper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trat once. Eliza Long (Wife) 12:19 Glyuit Pead, Clinton, M. 20735 and Disnosition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State Lee Crematory Oct 1, 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licenses Janis M. Atrans Alexandira Ferry Rd, Clinton, MD 20735 mo0257 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sepsis /Medical Due to (or as a consequence of): Examiner Neutropenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Uniseas or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Metastatic Small Cell Lung Cancer
Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown Completed Myocardial Infarction 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 ∰No certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 patient this 27. Manner of Death 1 XXatural 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou. Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the within ; 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D41752 Sept 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bergit Schoellmann, M.D. 1500 Forest Glenn Rd, Silver Spring, MD 20910 32 Aegistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

0 3 2005

			1 - For Stete Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of Hea rtificate of De	alth and Me eath	ental Hygie		31912
			Decedent's Name (First, Middle, La	ist)			- 2	2. Date of Death		3. Time of Death
ı	Physici /Medio		Edward	W		Llovd		Month Sept. 2	Day Year 7. 2005	9:50PM ^M
П	Examir		4a. Facility Name (If not institution, gir			4b. City, Town, or Lo		mp.	4c. County of Deat	
	Funeval		Chesapeake Hospi 5. Social Security Number 6.		yrs. last birthday)	Linthic If Under 1 Year If	11m Under 24 Hrs.	3 Date of Birth	Anne Ar	undel
Н	Funeral Director			1 1 2 F 7 3	Van	Months Days F	Hours Min.	B. Date of Birth (Month, Day, Ye		nplace (State or Foreign untry)
	ъ		Usual Residence of Decedent)			Dec. 16,	1931 Ma	ryland
	nylan how		10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Anne A	rundel (len Burr	nie .				1 ☐ Yes 2 ☐ Ho
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	ath w	ral	125 Glen Lea Driv			21060)		II.S.A.	
	er de Itams	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13. \	Was Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Speci Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Amer Black, White	
36	rs afte	byF	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No S	Specify:		Specify:	
몽	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show than "natural" or itams 23a or 28a-f show he Madeal Examinator must be notified at	edt	15. Decedent's E		16a Decer	dent's Usual Occupation	0	166	. Kind of Business/l	hite
75	n 72	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done during NOT use retired)	ng most of working	7	. Killa of Businessy	industry
212	d with	Eo	6	N/A	T	Electrician			M 7 1	D D 1
٦	e filed at Hygie othar vant. II	Bec	17. Father's Name (First, Middle, Last			18.	. Mother's Name (First, Middle, Maid	Maryland den Sumame)	Dry Dock –
Maryland 21215-0036	should be ind Mental marked o	ToE	Walter		L1oyd		Marie		Byrne	
ar.	2 sho and is ma		19a. Informant's Name/Relationship	Type, Print)	19b. Mailin	g Address (Street and	Number or Rural I	Route Number, Cit	ty or Town, State, Z	ip Code)
	and ealth m 27 nar tr		Joan M. Lloyd (Y	Wife)	125	Glen Lea I	Drive Gle	en Burni	. Maryla	nd 21060
altimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-1 show iny or other traumatic event. Ite Madical Examitter must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Dat	te 20c	Location - City or 1	Town, State
≣	t. Pa tmen tant: jury		`4 □Donation 5 □ Other (Special			11 Cemeter			cooklyn Ma	ary1and
Ba	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		21. Signature of Funeral Service Lice	llen	M 22	Name and Address of CCully-Poli	r Facility yniak Fur tansco Ar	neral Hom	ne, P.A.	ryland 21225
			23a. Part1. Efter the disease, or com shock, or heart failure. List only	plications that caused the d	eath. Do not ente	er the mode of dying, su	uch as cardiac or r	espiratory arrest,	emore, ria.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Small	cell.	lung	Comcer			Onset and Death
	/Medical		resulting in death)	Due to (or as a con-	sequence of):	9				
	Examiner	_	Sequentially list conditions,	b						
/	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of).					
y	xecui and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of);				-	
9/89	ificate be executed g physician and as the burial-transit			d						
9	ifficat g phy as the	edlcal								
ROX	death certifi e attending I od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of deliv	rery
	ed for	Completed by Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of		Other (specify)			Month	Day Year
J O	that the de ned by the a detached t	Phy	9 Unknown							
Š	requires that the neen signed by th hould be detache	þ	Part II. Other significant conditions of	contributing to death but not	resulting in the un		Part I.	23e. Did tobacc	o use contribute to	
Ö	w require been sign	eted	000000000000000000000000000000000000000	-		1		I DAPT es	2 NO 3 Pro	bably 4 Dunknown
Vital Records,	The law cate has b page 2 st	du						24a. Was an autopsy performed.	24b. Were autoprior to co	opsy findings available ompletion of cause of
_ 	ifcian: Th certificate rector, pag							1 ☐ Yes 2 🖫	No 1 ☐ Yes	212 No
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient		. Place of Death (C			MHOSPICE
0	g Phys er this eral di	⊢	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?		5 L Residence d. Describe how in		W) 14038 1 C3=
<u></u>	Attanding F ir death. actor: After by the funer	ig	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes			,	
UIVISION	al or Attandin s after death. Il Diractor: Af d in by the fur	ii	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		t home, farm, stre	et, factory, office	28f	Location (Street City or Town, Sta	and Number or Run	al Route Number,
5	tal or	Certification:	Tomores	building, etc. (ope	scriy)			City of Town, Ste	110)	
	To tha Hospital of within 24 hours at To tha Funaral D completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysicien: To the best of my linner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time, destigation, in my opinion	late and place, and n, death occurred	due to the cause at the time, date a	(s) and manner as s nd place, and due t	stated. o the cause(s)
	To the To the Complex complex	Me	29b. Signature and title of certifier	20	_	29c. License nun	mber	29d. D	Date signed (Month,	Day, Year)
			1 CAKN	de Dy	un	Nu.	2820		128/05	
	.[]		30. Name and address of person who	completed cause of death (I	tem 23a) (Type, F		xoxo		1140101	
	7		Christopher	deBoria	3708	mount	rain R	d. Pas	odeno.	m 0 21122
	Sta	_	31. Date filed (Month, Day, Year) OCT 0 3 2	32. Figistrar's Sig	gnature	M.				
	Registra	ır	001032	UUJ PROPER	No Page					

Patient Known as David S Levin

Please Type of Brint in Black Indelible of State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year DAVID SAMUEL LEVIN September 1522 M 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Sinal Baltimore Baltimore city N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 07/09/1915 217-05-4335 90 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23e or 28a-f ehow the Medical Examiner must be notified at MD BALTIMORE BALTIMORE Director 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3402 TUSLA ROAD 21207 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1 N Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married -2 Married 1 Yes 2 No Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BAKER 10 BAKFRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental LEVIN **ABRAHAM** ၉ BESSIE UNOBTAINABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i MAURICE LEVIN / SON 34 BON BON COURT -REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its eny injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO 09/30/2005 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 1000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial **Physician** infarction 1 day /Medical Due to (or as a consequence of): Examiner Heart disease A theresclerolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine anding physicien and use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death P.O. I 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2010 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖺 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. М 1 Yes 2 No 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

UC1 U 3 ZUUD

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Ida McFadden Mae September 27, 2005 2234p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2601 Madison Street Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F Director 251-50-2262 Yrs. 73 8-14-32 S.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Md. NA X Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2601 Madison Street 238 Apt. 312 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? "natursi", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avant, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Homemaker Other People Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unkn Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Daniels 2326 Garrett Ave., Baltimore, Md Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Fprest Vet Owings, Mills, Md. 21. Signature of Juneral Service Licensee. 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. Part 1. Enter the disease, or complice shock, or heart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknowh 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) O detached 9 Unknown ģ Records, P. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \(\subseteq \) No 24a. Was an certificate 1 X Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: d in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dira 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier Medical 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) Sept. 28, 2005 30. Name and address of person who completed oduse of death (Item 23a) (Type, Print) Baltimone, III Penn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 2005

State of Maryland / Department of Health and Mental Hygien 2015 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) EPTEM 62738, 2005 **Physician** 2:34AM Alice Mae Morris /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctors Hospital Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | 7. | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 | 1919 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 7 7 Yrs. 577 40 9972 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Danbury Drive 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 √No If Yes, Give AX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XN Specify: Specify: Be Completed by White 3 ♥ Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker les 1 and 2 should be filed of the lealth and Mental Hygie of Health and Mental Hygie If itsm 27 is marked other to ther traumatic event, III. Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herbert Alexander Ruth A. Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Morris II (Son) 1008 Danbury Drive, Bowie, MD 20721 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of H ent: If its XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or ance. Cedar Hill Cemetery Oct 3, 2005 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bio ise 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 400153 Alexandira Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician ercent of may disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner s a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes X Y ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ applible side 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1- Natural 5 Pending death. investigation 1 Yes 2 No To the Hospital or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 52261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Apin 2005 32. Resistrar's Signature 31. Date filed (Month, Con Year) Registrar

	i er		1 = For Amend Item Registrar Amend Item	State of Marylar #19a PerFH C8 8 Per FH C848	nd / Depa /4810//2 3 10/03	rtment o	of Health and of Death	Mental Hyg	giene Reg. N2 0 0	5 31916
MV	Physici	an	1. Decedent's Name (First, Middle, Last			RRIS		2. Date of Dea Month	ath Day	3. Time of Death
167	/Medic	al	WAYLAND 4a. Facility Name (If not institution, give	street and number)	1001		vn, or Location of Dea	Septemb	er 26 2	005 1027 M
	, Funeral Director	ier	1674 Darley Ave 5. Social Security Number 6. Se 2/3-34-2292	nue	last birthday) 7 Yrs.	Balt If Under 1 Y	imore			Birthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits
	a-f eh	ctor	MD	B	ALTIM	OPE				1 Yes 2 □ No
	ith the	Dire	10e. Street and Number	1		10f. Zip Co	de		10g. Citizen of Wh	
	eath v	eral	1674 DARLEY 11. Marital Status	HVE, 12. Was Decedent Ever in U	I	las Decedent	2/2/3 of Hispanic Origin? (Specify Vac or No.	USA 14 Bace	American Indian,
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, it a Madrial Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Yes, specify	Cuban, Mexican, Pue	rto Rican, etc.)	Black,	White, etc. BLACK
21215-0036	nn 72 ho n "natur Madical	Completed	15. Decedent's Edit (Specify only highest grad	cation le completed) College (1:4or 5+)	(Give k	ent's Usual O find of work of ONOT use r	one during most of wo	orking	16b. Kind of Busi	ness/Industry
	ed within /giene. er then "	Com	813 GRADE	N/A	AIR F	LTERS	INCI		INDUST	
Maryland	ould be fill Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) JAMES ALLEN	NORKIS			ANNIE	me (First, Middle,	CONWA	1
Mar	12 should hand 7 le m	2	19a. Informant's Name/Relationship (T)	T 1907-000			reet and Number or R	4		2 /
	s 1 and f Healt ftem 2 other		SHARON MOKK 1: 20a. Method of Disposition	/Daughter	Place of Dispos	ition (Name	GRLAND S	Date Date	TO MD. 20c. Location - C	
E	T T e		1/4 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					3.2005	BALTING	ec mo,
Baltimore	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service Licens	Heres	2	1316.1	ULIVER ST.	BALTIMO	KE, MD	et MD. d Funeral Sovice 21213
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Finat	lications that caused the dea ne cause on each line.	th. Do not ente	r the mode of	dying, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	Medical Examiner physician and sthe burial-transit	dical Examiner	resulting in death) Esquartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	quence of):			DIC	EARE	
Box 6	death certif e attending id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a 9 □ Unknown	al death 3 🗍	Ectopic pregr Other (specif			23d. Date Month	,
, P.O.	requires that the een signed by th hould be detache	y Phy	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying caus	e given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ğ	w require been sig should b							1 🗆 Y	′es 2 □ No 3	Probably 4 Munknown
al Records,	The law ate has b page 2 si	Completed	200-200-200-200-			_		24a. Was a autop: perfor	med? pri	ore autopsy findings available or to completion of cause of ath? Yes 2 \(\sum \) No
of Vital	Physicien: Th this certificate rat director, pag	Be c	25. Was case referred to medical examiner?	Hospital:	150/0		Other	ath (Check only or		
	fter fter	ıtlon: To	1 Yes 2 No 27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of tnjury		1 Nursing Injury at Work? 1 Yes 2 No	Home 5 Resid	ence 6 [xtOther ow injury occurred	THE THE
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, of	fice	28f. Location (S City or Tow	itreet and Number n, State)	or Rural Route Number,
	e Hospit 24 hours e Funere letely fille	edical C	253 Centifier 1 ☐ Centifying Phy (Check only one) 2 ☑ Medical Exami	ner: On the basis of examination and manner stated.	ation and/or invi	occurred at the	ne time date and plan my opinion, death occ	e, and due to the ourred at the time, o	date and place, an	not as stated. d due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Li	cense number	2	29d. Date signed (Month, Day, Year)
	525		> Unel2			0	CME		September	., 27, 2005
	3		30. Name and address of person who co	CALL C	m 23a) (Type, F		1 District			
E1	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign.	ature _		Penn Str	eet Balt	imore, 1	laryland 21201
ME	Registr		OCT 0 3 200	5 Resource D	1 Dogs	Se de la constante de la const				

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Ross Zimmerman Pierpont 6:00 A^M September 30 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 215 Belmont Forest Ct., #408 Timonium Baltimore Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 7, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□ F Yrs. 578-12-8124 88 Mary land Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h Counts or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Timonium Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Belmont Forest Ct., #408 United States 21093 "natural", or itsms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Genral Surgeon Medical is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Itsm 27 is marked oth any julyy or other traumatic avant page. Ethel Celeste Zimmerman Edwin L. Pierpont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Pierpont/wife 215 Belmont Forest Ct., #408 Timonium, MD 20a. Method of Disposition
1 □ Burial ★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 10-6-05 Baltimore, Maryland GreenMount Cemetery 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee lohu O 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Arterioscherotic Cardiovascular Disease **Physician** 15 Vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknows 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 this certificate has 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Medicai Certification: To 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. noietely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and total of certified 018667 Lebut 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Trimble H:11 CT, Lutherville, Maryland 21093 PHILIP Militello, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg 200 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vaar **Physician** Mary Virginia Riley 9:46 A September 29, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 □ F 212-32-3665 92 Director 21, 1913 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event, the Medical Examination ust by multibul at 1 ☐ Yes 2 ☑ No Harford Bel Air Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 800 Coconut Court, Apt. H Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Menial Hygiene. Int: If Item 27 Is marked other than "netural", or Ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White Completed by 3- Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeper 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Mae Ward Edgar Elwood Grafton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:: Department of Health at Important: If Item 27 Is any injury or other trau E. Ann Riley/Daughter 800 Coconut Court, Apt. H, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gds. 10-4-05 Bel Air, MD 4 Donation 5 Other (Specify) 21. Signatury of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Myocardial Acute Physician hour disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit Due to (or as a consequence of): use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed RILEY MARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 PROutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٢ this 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

OCT 0 3 2005

31. Date filed (Month, Day, Year)

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

nch

32. Registrar's Signature

2

ORIGINAL

North Ave Bel Air, Md. 21014

Amend item#8, perfff, 6848, 10/3/05 TT State of Maryland / Department of Health and Mental Hygien 0 0 5 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month IRIAN TNER 350PM mber 28 2005 /Medical Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner stown nwe 101 anda a more Date of Birth 12/27/19 Birthplace (State or Foreign (Month) Day Year 11/27/1917 BELARUS If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🗓 F Director 214-53-7695 87 Yrs Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28e-f ehow Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTT LEVEL ROAD 21208 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. WHITE 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 X Widowed 4 ☐ Divorced "neturel" other then "netur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ie marked RATNER LEIB IDA MINTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar importent: if item 27 ie eny injury or other treu once. 5 COBBLESTONE CT. APT. 2-A - BALTIMORE, MD 21215 YELENA BORD / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 09/30/2005 | FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DM moni /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed physicien end s the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) per. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has t irector, page 2 s autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 Inpatient ë ۵ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this rector: After this by the funeral of 28b. Time of Injury Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and Ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) mber 28 2005 se andallstow 540 Louv Koac 31. Date filed (Month, Day, Year)
OCT 0 3 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiena Reg. No. 005 For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day SEPTEMBER 28, 2005 **Physician** 7:42a M DAPHNE C.H. ROSEBORO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON BALTIMORE GILCHRIST HOSPICE CENTER | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | 1-29-1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F Yrs. ANTIGUA 71 145-42-5609 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examalar must be collined at 1 Yes 2 □ No N/A BALTIMORE Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 1712 E. 27th ST. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK by 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Elementary/Secondary (0-12) Hygiene. -12-NURSING ASSISTANT HEALTHCARE and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental GEORGE PETERS AMELIA RICHARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: if item 27 is 1713 WOODBOURNE AVE. BALTIMORE, MARYLAND 21239 JEROME PETERS (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □Removal from State 5 permit. Pag Department Important: II any njury or WOODLAWN CEMETERY 10-4-2005 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) ral Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of E 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) PANCREATIC **Physician** 20 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical the as attending i 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1 Yes Vital ieral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence & Other (Specify) HOSPICE 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3□ DOA ٤ ō 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural
2 Accident Division or Attending 5 Pending 1 Yes 2 No investigation 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 4 Homicide within 24 hours a 21th Certifier Contriging Physiciam To the best of my knowledge, death consider the time, date and place, and dire to the name(e) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Baltimore MD 21204 Ktauliner MD, 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 3 2005 Registrar

3000

80

8

SAPTAR

			1 - State of Maryland / Department of Health and Me Certificate of Death	ental Hygier		31921
ĺ	Physic			2. Date of Death	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	September	4c. County of Dea	th
	Funeral		Genesis Eldercare Caton Manor Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	N/A	
	Director		214-44-8911 1 M 2 F 58 Yrs. Months Days Hours Min.	Oct.28,	1946 S.	thplace (State or Foreign cuntry) Carolina
	aryland ehow	<u>_</u>	10a. State 10b. County 10c. City. Town or Location			10d. Inside City Limits
	the Mire	recto	Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code	100.0	Citizen of What Co	1 X Yes 2 No
	s 23e or	rai D	314 N. Lyndhurst Street 21229		US	A
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f ehow any injury or other traumatic avent, the Medical Examinar must be notified at once.	by Fune	Maryland N/A Baltimore 10e. Street and Number 314 N. Lyndhurst Street 21229 11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 1 □ Yes 2 □ Not Year or Dates: 1 □ Yes 2 □ Not Year or Dates:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	in 72 ho n "natu	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired)	g 16b.	Kind of Business	
	filed within Hygiene. other than "			So	chool S	
land	uld be fi fental H rked ot tic aver	To Be	17. Father's Name (First, Middle, Last) Columbus Crawford 18. Mother's Name (Willard	^{(First, Middle, Maide} dean Joh		
Maryland	12 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)			
	of Healt of Healt litem 2		20a. Method of Disposition 20b. Place of Disposition (Name of Da		Location - City or	
Baltimore,	artment artment ortant: fi njury o		'4 Donation 5 Other (Specify) Western Star Cem. 10/			e,Maryland
Ba	permit. Departr Imports any inji		ewy Camb 5240 Riesterstown	n Rd. Ba	ris Fu	neralHome
	Dhusisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions b. Me has for he lung Cencer			Fourty.
		Jer	Sequentially list conditions, if any, leading to immediate cause. E.i.e. Uniderlying Cause. (Disease or injury)			Tew malts
8	kecuted and I-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
68760,	ificate be executed g physician and as the burial-transit	edicai E	d	-		
	n certifica anding ph use as tl	/Med	IF FEMALE: 23b. Was decoded property 23c. If yes, outcome of pregnancy		02d D-ts -6 d-1	
P.O. Box	that the death certi ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 1 No 9 Unknown		23d. Date of deli Month	Day Year
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
Vital Records,	sician: The law r certificate has be rector, page 2 sh	Completed by		24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
f Vit	ıysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		6 □Other (Spec	rifu)
on of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 Work? 1 Natural 5 Pending	d. Describe how inju		,
Division	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	2 Cuident	If. Location (Street a City or Town, Sta	and Number or Ru	ral Route Number,
	spitel cours at neural D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	id due to the cause/	s) and manner as	stated
	the Ho hin 24 h the Fu mpletely	Medicai	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date ar	nd place, and due	to the cause(s)
)	T wit		29b. Signature and title of certifier 29c. License number D 0 0 6 2 6 3 4	29d. Di	ate signed (Month	i, Dey, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		. 1.3	
	Sta	_	31. Date filed (Month, Day, Year) OCT 0 3 2005 32. Registrar's Signature	7		
	Registr	ar	UCTU D 2000 Marson Do Maries			

Adeline Snith

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 07 05 AM 09 David Simmons. Jr. 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Baltimore HOPKING Core Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□ F Director 215-28-2654 69 10 29 35 NC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatth and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, tra Medical Exemires must be inclined at Director Baltimore 1 XYes 2 No MD NA 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21223 U.S.A. Completed by Funeral 2202 Penrose Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Food Company na Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Simmons Mary Pettaway ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Simmons-Bell 4000 Windsor Mill Blvd, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 □ Other (Specify) Woodlawn 9/29/05 Baltimore Co, Md 21. Signature of Funda Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** STOKE resulting in death) /Medical Due to (or as a consequence of): Examiner atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner THE TONIN Due to (or as a co sequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ei br 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ဥ 1 Yes 2 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Manyland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Attending Physician:

Box 68760,

P.0.

of Vital Records,

Division

burial-transit

as the

signed by the attending the detached for use as

peeu

has page 2 certificate

this

To the Hospital or Attending Phy within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral or

director,

and

physicien

Barron 31. Date filed (Month, Day, Year) 03 2005

Jereny

702 6. 404 54 32. Aggistrar's Signature

30. Name address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopking at Fees with

00051189

9120700

Baltimore

21211

		•	For State Registrar	State of M	laryland	•	artment of H		d Mental Hyg	iene 2.11	15	31923
	Physici		Decedent's Name (First, Middle, La.		nna S	Sartor	i		2. Date of Dea Month Septemb	th Day	Year 2005	3. Time of Death 6:30 P M
	/Medic Examir		4a. Facility Name (If not institution, give	e street and number	r)		4b. City, Town, o	r Location of D		4c. County		0.00
1	LXami	161	Genesis Heritage	Meridian	Cente	er	Dunda:	lk		В	Baltin	more
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. Ia		If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day) Feb. 23	Year)	9. Birthp Coun Mary	
			Usual Residence of Decedent		-,					•		
	show	_	10a. State 10b. County	timore	10c. City,	, Town or Lo	cation	Dund	alk		1	0d. Inside City Limits 1 ☐ Yes 2 No
	Me Me Me Me	Director	7	CIMOLE			10/ 7: 0-1-			0g. Citizen of V	Min and Carre	
	with t	ă	10e. Street and Number	n 3			10f. Zip Code	2122		United		•
	eath	eral	1832 Dunmere	ROad 12. Was Deceden	t Ever in U.S	S. 13. V	Was Decedent of H					an Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Modical Exercities reast be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	i?]No		f Yes, specify Cub 1 □ Yes 2X No		? (Specify Yes or No- uerto Rican, etc.)		k, White,	
21215-0036	2 hou	ted	15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	usiness/Inc	dustry
215	hin 72	Completed	(Specify only highest gra	ide completed) College (1-4oi	5+)	(Give life.	kind of work done DO NOT use retire	during most of d)	working			
21	giane giane ar the	Com	12 Years		,	Re	tail Sal			G. C.		
nd	be filed tal Hygid d other event, I	Be (17. Father's Name (First, Middle, Last,						Name (First, Middle,	Maiden Sumam	e) Unk	•
yla	should trud Ment marked umatic o	ပ		ie Lewis					llie Oval			
Maryland	2 sho		19a. Informant's Name/Relationship (Robert Sartori	Туре, Print) (Son)		1			<i>r Rural Route Numbel</i> Dundalk, M	-		222
	1 and Health am 27 Iher tr		20a. Method of Disposition	(5011)	20b. Pla		sition (Name of	Road		20c. Location -		
Baltimore,	ages or of		XXBurial 2 ☐ Cremation 3 ☐		e ce	emetery, crer	natory or other pla	· I			•	
ij	it. Partmentant		□ Donation 5 □ Other (Specification 21. Sign Tree of Funeral Service Licer		Sac				. 10/3/200			
Ba	permit. Pages 1 and Department of Heali Important: if item 2 any injury or other 2006.		1)0-(. (a. C				l Home of Dundalk, M			
			23a. Part1 Enter the disease, or com snock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	. Do not ent	er the mode of dyir	ng, such as car				Approximate Interval Between
4	Physician	10 S	Immediate Cause (Final disease or condition	2	de	w'c	le	nt	Ris	do)	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):	,					0
	Examine	_	Sequentially list conditions,	b. Due to (or a	s a copsequ	Della of):	seis	-			-	your
	ted nsit	nine	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or a	()	Price on):						ð
΄,	execunand nand ial-tra	Examiner	that initiated events resulting in death) Last	C Due to (or a	s a consequ	ence of):						
8760,	cate be executed physician and the burial-transit	dical		_ d								
9	ing ph e as t	Med	IF FEMALE:					-		1	-	
Вох	death certifi e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3	Ectopic pregnanc	у		23d. Dat Mor	e of delive	ery Day Year
0.	that the death certific ed by the attending p detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time of de	ath 5L	Other (specify) _					_
Φ.	requires that the een signed by th nould be detache	/ Ph	Part II. Other significant conditions	ontributing to death	but not resul	ılting in the u	nderlying cause gr	en in Part I.	23e. Did to	bacco use conti	ribute to th	ne cause of death?
Records,	uires l signe	d by	Variet	-'a					1 🗆 Y	es 2 🗆 No	3 🗌 Prob	ably 4 Unknown
00	> Q 70	lete	(SE						24a. Was a	n 24b. V	Nere auto	psy findings available
Re	0 5 0	Completed						-	— autops perform 1 ☐ Yes	med2 c	orior to cor death? Yes	mpletion of cause of
Vital	sician: The certificate rector, pag	O O	25. Was case referred to medical					26. Place of	Death (Check only or		1.03	20140
>		To B	examiner? 1 Tyes 2 No	Hospital: 1 Inpai	tient 2 🗆 E	ER/Outpatier	t 3 DOA Ott	ner: 4 Nursin	ng Home 5 Resid	ence 6 Othe	er (Specify	v)
n of	ding Phys	ü	27. Mann Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D		28b. Time of	28c. Inju	ry at rk?	28d. Describe h	ow injury occurr	ed	
Sio	Attending r death. sctor: After y the fune	atlc	2 Accident investigation				M 1	Yes 2 □ No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	200. Flace 01 11	njury - At hor etc. <i>(Specify)</i>	me, farm, str ')	eet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rura	l Route Number,
	Hospital of the source of Funeral Distriction (1997) in the source of th		29a. Certifier 1 Certifying Pt	veicios: To the bar	ot of mustime	uladas dari	a accurred at the co	mo doto cod -1	lane and due to the	aucolol and mi	nnor c = 1	totad
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		niner: On the basis and manners	of examinati	ion and/or in	vestigation, in my	ppinion, death o	lace, and due to the coccurred at the time, d	ause(s) and ma ate and place, a	and due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens			9d. Date signed		
•	05		Mu	NCI	up		Do	1008	358	Sept	30	2005
	2 1		30. Name and address of person who	completed cause of		23а) (Туре,	Print) 152	4 A;	MESHI	ervo	JA ?	5
6			WHAMAV. 8.	- 1 1 [- 1	-1 0		1-607	14. 1	MARYCI	4211 6	1100	13
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32. Heges	trar's Signati	A A	pode					

5-6650 KG		Shelton Un 1 - State Ragistrar	npend :	ase Type or Pr item#23a,27 State of I		E,G848,10 artment of l artificate of		Mental Hy	giene Reg. No.20	05 3192
Physicia /Medic		Decedent's Name JOH			HELTON			2. Date of De Month Septem		3. Time of Death
Examin	_	4a. Facility Name (I		on, give street and numb	er)	4b. City, Town, Catonsv	or Location of Death		Balti	y of Death Lmore County
Funeral Director		5. Social Security N 217-58-97	69	6. Sex. 7.	Age (In yrs. last birthday 47 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11-10-	rth ay, Year) -1957	9. Birthplace (State or Foreig Country) Maryland
ehow	٥٢	Usual Residence of 10a. State Maryland	10b. County	y cimore	10c. City, Town or I	ocation nsville				10d. Inside City Limit
with the h	Direct	10e. Street and Nur 535 Fores	mber			10f. Zip Code 21228	3		10g. Citizen of United	What Country? States
permit. Peges 1 end 2 should be tited within 72 hours after deeth with the Maryland Depertment of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow ery injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Ma	12. Was Decede	ont Ever in U.S. as? Social No. Coast Guard Social 13	Was Decedent of If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Ra Bla Specii	ce - American Indian, ick, White, etc.
thin 72 hou e. en "nature Medical E	Completed by	(Spec	ify only high	nt's Education est grade completed)	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire			16b. Kind of E	Business/Industry
Ibe filed wintal Hygien ad other the	Be	12 years 17 Father's Name Homer She		, Last)	Self	employed,	18. Mother's Nar		, Maiden Sumai	
nd 2 should lith and Me 27 is mark r traumatic	To	19a. Informant's N	ame/Relation	4	19b. Mai 535 I	ling Address <i>(Str</i> eet Forest Lar	and Number or Ru ne Catons	ville, N	er, City or Town Maryland	l, State, Zip Code) 1 21228
Peges 1 er lent of Hea nt: If Item		20a. Method of Dis 1 ABurial 2 4 Donation	Cremation	3 □Removal from Sta	20b. Place of Disposers 20b. Place of Disposers cometery, critical Lorraine	position (Name of permatory or other plate Park Ceme	etery 10-	Date 5-2005		- City or Town, State vn, Maryland
		21. Signifure of Fu 23a Fart1. Enter shock, or hea Immediate Gauss	he disease, o	J. Wayne (or complications that cause only one cause on each	Osterling Sed the death. Do not en	nter the mode of dyi	olyniak fi tapsco Av ng, such as cardiad	e. Bait	imore, r	A. Maryland 21225 Approximate Interval Between Onset and Death
Pnysician /Medical Examiner		disease or condition resulting in death)	òn	Due to (or	tic and Coc as a consequence of):	aine Into	xication			
ate be executed sysician end he burial-transit	icai Examiner	Sequentially list con any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	5	c	as a consequence of):					
Attending Physician: The law requires thet the death certificate be or decor. After this certificate has been signed by the ettending physicis by the funeral director, paga 2 should be detached for use es the burner.	by Physician/Medica	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 0 9 □ Unknown	: months? ⊒ No		n 2 ☐ Fetal death 3 tat time of death 5	☐Ectopic pregnanc ☐ Other (specify)	у			ate of delivery onth Day Year
quires thet on signed b	ed by PI	Part II. Other signi	ficant condit	tions contributing to deat	h but not resulting in the	underlying cause gr	ven in Part I.		tobacco use con Yes 2√2No	stribute to the cause of death?
The law requir ste has been si paga 2 should	Completed								psy ormed?	Were autopsy findings availa prior to completion of cause of death? 1 Des 2 No
ding Physician: The lav h. After this certificete has funeral director, page 2	To Be (25. Was case reference examiner?		Hospital: 1 ☐ Inp	atient 2 ☐ ER/Outpation	ent 3□ DOA Ot	26, Place of Dea			her <i>(Specify)</i> at scen
r Attending Ph er death. rector: After th by the funeral	Certification:	27. Manner of Deal 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pend inves 6 Could	tigation 9/30/		0 P ⁴ 1	ryat rk?]Yes 2★No	28d. Describe	how injury occur	
the Hospitet or hin 24 hours afte the Funeral Dire	cai Cer	zea. Cerufier		foun	d at home	do occurred at the d	me, date and place	Caton	sville,	MD anner as stated.
To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29b. Signature and		Il Examiner: On the basi and manner	e stated.	29c. Licens O.C.I	se number		29d. Date signe	ed (Month, Day, Year) 1, 2005
		30. Name and add	MD	n who completed cause of the cause of the completed cause of the completed cause of the completed cause of the cause of the completed cause of the cause		e, Print) 111 Penn	Street, B	altimor	e, Maryl	land 21201

2			For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan		artmen rtificat					eg. No2	005	3 1 9 2 5
	Physici /Medic		Elsie TEAGU	e						Month	2 ^{Day}	2005	10:37AM
	Examin		4a. Facility Name (If not institution ove s			4b. City,	Town, or	Location of		•	1	ounty of Death	
	Funeral		University of Mary 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under		M 61		Date of Birth		NA 9. Birth	place (State or Foreign
	Director		218-40-0747	M 2 🗗 62	Yrs.	Months	Days	Hours	^{Min.} Jų	Date of Birth (Month, Day ne 30	194	2 Mary	Zland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Ba-fet	Director	Maryland Harford	. E	Bel Air								Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip						n of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentall Hygiene. Important: if tiem 27 le marked other then "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, Ite Medical Examinar must be notified at page.	by Funerai	102 A Seevue Court 11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec			in? (Specify Puerto Rica	/ Yes or No- an, etc.)		A. Race - Ameri Black, White, pecify: Whi	etc.
2-0	"natur	leted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	rk done d	urina most	of working		16b, Kind	of Business/Ir	ndustry
21215-0036	withir piene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		s Cle	,				Re	tail Sa	ales
pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)							irst, Middle,	Maiden Si Ande	•	
Maryland	should nd Men marke matic	P.	Odill Oscar Crous 19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address	(Street a	Glad		arie oute Numbe		Town, State, Zij	Code)
, Ma	is 1 and 2 in Heelth ar item 27 le		Curtis Teague - Hu					Court				land 21	
ore	ages 1 or oth		20a. Method of Disposition D☐ Burjal 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Disponentery, cremotery, CMC	natory or c	other place		Date			tion-City or T t, Mary	
Baltimore,	mit. Pa partmer portant injury		4 Donation 5 Other (Specify) 21. Sign fre of Fun relieved License		-		_					Home,	
ä	Depa Impo Impo eny i		Il and	1	1	$317 \mathrm{C}$	Cokes	bury	Road,	Abing	gdon,	Maryla	and 21009
	Physician /Medical		23a. Part 1. Enter the disease, or complisshock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line. Due to (or as a conseq				, such as c	cardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
3760,	physicien and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (un as a conseq	titis uence of).								
O. Box 6	death certif e ettending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic p					23	d. Date of deliv Month	ery Day Year
rds, P.O.	es be	by	Part II. Other significant conditions con	stributing to death but not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	_		he cause of death? bably 4 □Unknown
Œ	The ete ha	Completed	100						_	24a. Was a autop: perfor 1 Yes	sy	24b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vita	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No H	lospital:	ER/Outpatier	nt 3 🗆 D0	Othe	· F:		heck only or		☐Other (Speci	6.0
	ding h. After fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work		28d	. Describe h			(9)
É	o affe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factor	y, office		28f.	Location (S City or Tow		Number or Run	al Route Number,
	Hospital 24 hours a Funerei	edicai	29a. Certifier Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred vestigation	at the time, in my op	e, date and pinion, death	place, and h occurred a	due to the c at the time, d	ause(s) ar late and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				c. License					signed (Month,	
	2		Mr.	mo			p/	854	17		Sep 7	+ 24	2005
	10		30. Name and address of person who co	la mi	n 23a) (Type, 22 L	Print)	Gra	ene	S+	Bala	ino	12 M	2005
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature do	de	•						

	State of Maryland / Department of Health and	d Mental Hygiene
	1 - State Registrar Certificate of Death	Reg. NZ 005 31926
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
/Medica	boilin kichard inomas	94
Examine		0 11
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Hrs. 8 Date of Birth 9 Birthplace (State or Foreign
Director	214-12-3283 12 M 2 F 82 Yrs. Months Days Hours N	Ain. (Month, Day, Year) Sept. 30,1922 West Virginia
and w	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Mary!		1 ☐ Yes 2 ☒ No
uter death with the Mau uter death with the Mau ritems 23s or 28s-f si niner must be notified	Maryland Baltimore Midd	le River 10g. Citizen of What Country?
th with	1301 Washington Irving Lane 21220	United States
r dea	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt	? (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36 is after	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No IYes, Give WWII 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	Specify:
1215-0036 within 72 hours after death with the Maryland sne. then "natural; or Items 23s or 28s-f show the Mudical Examinar must be notified at	15. Decedent's Education 16a. Decedent's Usual Occupation	White 16b. Kind of Business/Industry
215 215 215 30 73 30 73	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	working
100 mas	8 Years Business Owner/Barbe	
and 2	17. Father's Name (First, Middle, Last)	Name (First, Middle, Maiden Surname)
arylanos should be and Mental simerked oumstic eve	1.dbboll 1	stelle Luzier Rural Route Number, City or Town, State, Zip Code) 21220
44 01 00 00		ving Lane Middle River, MD
rre, M s 1 and 2 f Health ltem 27	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Baltimor permit. Pages Department of Importent: If the eny injury or o	1 Surial 2 Cremation 3 Removal from State 4 Dogastion 5 Dother (Specify) Helly Hill Mem. Gdns. 9	/26/2005 Middle River, MD
Baltime permit. Pag Department Importent: I eny injury o	21. Signature Fineral Syrics Licer 22. Name and Address of Facility Duda - Ruck Funeral	Home of Dundalk, Inc.
m gg = 9 g	7922 Wise Ave. I	Dundalk, Maryland 21222
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	diac or respiratory arrest, Approximate Interval Between Onset and Death
Physician // // // // // // // // // // // // //	Immediate Cause (Final disease or condition resulting in death)	20 years
Examiner	Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observe of Injury that imitated events c.	
executed in and inal-transit	Cause (Disease of injury that initiated events c. Pue to (or as a consequence of):	
origin pe 90		
- 0 0		
Box 687	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant	23d. Date of delivery
P.O. Box 68 that the death certificated by the attending phy detached for use as it.	25. Was deceded program 1 in the past 12 months? 1 Yes 2 No 9 Unknown	Month Day Year
P.O. hat the de dd by the detached	9 Unknown	
ires the signed to be d	1 art ii, other significant containers contributing to death barrior resoluting in the disconying cause given in rearti.	23e. Did tobacce use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Cords, we requires been sign should be		
al Record The law require cate has been signated as been signated.		autopsy prior to completion of cause of death?
tifficate for. pa	25. Was case referred to medical 26. Place of F	1 Yes 2 No 1 Yes 2 No No No No No No No
of Vi	examiner?	g Home 5 Residence 6 Other (Specify)
on of Vita ding Physicien: After this certific funeral director,	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Injury Work?	28d. Describe how injury occurred
SiO Signath. Signath. Signath. Signath.	2 Accident investigation 3 Suicide 6 Could not be	COS La cabian (Chandan d Mumbana Sum / Stanta Mumbana
Division of Vital Records, its or Attending Physicien: The law requires the safter death. The Institute has been signed in by the funeral director, paga 2 should be considered in the funeral director, paga 2 should be considered by the formulated	4 Homicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
_ \$ 5 2 8 C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the cause(s) and manner as stated.
the Hospl in 24 hour the Funer pletely fill	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ccurred at the time, date and place, and due to the cause(s)
To the vithin company of the transfer of the t	29b. Signature and title of certifit	29d. Date signed (Month, Day, Year)
	Answer M.D. RESUDO	0 9-24-05
6+1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Scott Link 9000 Franklin Square Drive Balti.	md 21237
State	21 Data filed (Month Day Veer) # 22 Decistrar's Signature Ve	111118 110.0/01
Registrar		

			5	State of Ma	ryland /	Department	of Healt	h and M	ental Hy	giene	3	
		•	For State Registrar		,	Certificate				Reg. No.	005	31927
	Physicia	an.	Decedent's Name (First, Middle	, Last)		100-00	oca c	C 1	2. Date of Dea	ath Day	th Year	3. Time of Death
	/Medic	al	THELMA_	nin atrest and number		VANCIN T	own, or Locati	ion of Death	septem	Der 20	unty of Death	5 6 BA
	Examin	er	4a. Facility Name (If not institution		EDLAL CE		77.77	100RE	CITY	10,000	N/A	
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last b	irthday) If Under 1	Year If Un Days Hou	der 24 Hrs.	8. Date of Birt (Month, Day	h y, Year)	9. Birth	place (State or Foreign intry)
	Director		220-18-5150	1□ M 2½F 79	9	Yrs.			Feb. 17			ryland
	land ow	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside City Limits
	Mary B-f ah	tor	Maryland 1	Baltimore			Dunda1	.k				1 ☐ Yes 2Ã No
	ith the	Director	10e. Street and Number			10f. Zip C					of What Cou	
	death with the Maryland me 23s or 28e-f show r must be notified at		1956 Church Ro	12. Was Decedent E	ver in U.S.	13 Was Decede	212		city Yes or No-		ited S	
	fter de	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? ed 1 ☐ Yes 2 ☐ N		13. Was Decede If Yes, specif			Rican, etc.)		Black, White	
5-0036	within 72 hours after ene. then "naturel", or Ite ne Medical Examine	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Tes 2	I⊈No Spec	спу: 			ecify:	White
2	natu	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a	 Decedent's Usual (Give kind of work life, DO NOT use 	done during i	most of worki	ng	16b, Kind	of Business/li	ndustry
2	withir lene. r then	omp	Elementary/Secondary (0-12) 11 Years	College (1-4or 5-	+)	Clerk				Payr	coll Se	ervice
g	be filed within 72 hours after death with the Marylan Hygiene. I Hygiene. I dether than "natural", or Itame 23a or 28e-f ahow avent, the Madical Examiner must be notified at	BeC	17. Father's Name (First, Middle,	Last)		CICIA			(First, Middle,		mame)	
<u>X</u>	should be nd Menta markad umatic av	To	Frank Schult						Schlut			
Maryland	0 4 2 2		19a. Informant's Name/Relations! Mr. Bernard J.		_	b. Mailing Address (1002 Alex					21014	
	s 1 and if Health Itam 27 other to		20a. Method of Disposition		20b. Place	of Disposition (Name	e of	-	ate		ion - City or T	
E O	0 0	,	1 🔀 Burial 2 🗀 Cremation 1 4 □ Donation 5 □ Other (S)		I -	awn Cemet	OTT	0/1/20	05	Bal ⁻	timore	, Maryland
Baltimore,	permit. Pag Deportment Importent: I any njury o		21. Socature of Funeral Service	Licensee	00	22. Name and Duda-R		acility neral	Home of	Dunda	alk, I	
	20529		23a Part1 enter the disease, or	complications that caused		7922 W	ise Av	e. Du	ndalk,	Maryla	and 2	1222 Approximate
	13		shock, or heart failure. List Immediate Cause (Final	only one cause on each lin	e.	THO STREET THE HOUSE	OC I	as cardiac o	i respiratory at	1031,		Interval Between Onset and Death
	ician edical		disease or condition resulting in death)	a. CHKU	consequence	VIC St	UK					4 HOURS
	Examiner		Sequentially list conditions	b. M40C	ARDI	AL 11	VFAT	2C770	\mathcal{M}			12 10215
4	sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	i of):	+ /	01581	220			HUEARS
7	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. JOC HC	consequence	17E/T/C/	<i>L</i>	JIOCI	700			11 94110
760,	a × a	call		d								
89	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Med	IF FEMALE:		4							
Вох	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal deat	h 3 Ectopic pre-				23d.	. Date of deliv Month	very Day Year
o.	the day the ached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,		7			
S, G	uires that the de signed by the a d be detached f	by P	Part II. Other significant condition	ons contributing to death bu	it not resulting	in the underlying car	use given in P	art I.		_		the cause of death?
ord	w require been si should t	ted							1/X	Yes 2□N	lo 3 Pro	bably 4 Unknown
Records,	e law has b	Completed							24a. Was autop		4b. Were aut prior to co death?	opsy findings available ompletion of cause of
_			25. Was case referred to medical				26 D	llace of Death	1 (Check only o	2 No	1 🗆 Yes	200 No
	ysicia is cert direct	o Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/C	outpatient 3 DOA	Othor		me 5□Resid		Other (Speci	ify)
Division of	Attending Physician: The Isr death. actor: After this certificate he by the funeral director, page	on: T	27. Manner of Death 1 ★Natural 5 ☐ Pendin	28a. Date of Injur (Month, Day	y Year) 28b.		c. Injury at Work?		28d. Describe h	now injury oc	ccurred	
Sio	I or Attendi after death. Diractor: A in by the fu	icati	2 Accident investig 3 Suicide 6 Could	not be 280 Place of Inju	Inv - At home	arm, street, factory,	1 Yes		28f. Location (5	Street and N	umber or Rui	ral Route Number,
<u>></u>	i Dite	Certification:	4 ☐ Homicide determ	building, etc	. (Specify)	arm, andon, radioly,	31100		City or Tou			
	To the Mospitel or At within 24 hours after of To the Funeral Dirac completely filled in by	ledical C	29a. Certifier X Certifyin	g Physician: To the best of Examiner: On the basis of	of my knowledg	ge, death occurred a	t the time, dat	e and place, a	and due to the	cause(s) and	d manner as	stated.
	the P	Medi	one) 29b. Signature and title of certifie	and manner sta			License numb				igned (Month	
)	Z iv C		from a fo	// Menir	a n	VION 6	255-1	900			-	26 th 2005.
	4		30. Name and address of person	who completed cause of de	ath (Item 23a	(Type, Print)				U 1(1	BA	LTIMORE
	lD		SUSAN BELL,	HEJOHNS!	HOPKIN	us hospi	TAL, 6	00 N.	WOZFE	STREE	TM	0,21260
	Sta Registi		31. Date filed (Month, Day, Year)	2005	ur's Signature	Course	,					
	ricgisti	-CII		B. OR. B. S. S.	- 4							

		1	- State Amend Item 2	State of M 2&Unpend I	aryland/f t em 23a&	epartm 2 per Certific	ent of H me G8 ate of L	ealth and 249 11–7- Death	Mental Hyg -05 tas	giene Reg. No.	005	31928
			1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath Day	/ Year	3. Time of Death
	Physici /Medic		Thomas Williams						Septeml	ber '	23, 200	5 6:20 P M
1	Examin	er	4a. Facility Name (If not institution, gi)			Location of Dear	th	4c.	County of Deat	h
0			Johns Hopkins		ge (In yrs. last bin		timore	If Under 24 Hrs	8. Date of Birt	h	9. Birtl	nplace (State or Foreign
3	Funeral Director			¹₹M 2□F 35		Yrs. Mor	ths Days	Hours Min	(Month, Da 11-19-		Co	h. D.C.
9	ס		Usual Residence of Decedent		100 City Town				, 11			10d. Inside City Limits
	anylar ehow	-	10a. State 10b. County		10c. City, Town							1 Yes 2 No
	the M	ecto	MD 10e, Street and Number		Baltimo		f. Zip Code		Т	10a. Citi	izen of Whal Co	44
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	Funeral Director		_			1213					,
	death ms 2;	nera	1738 N. Gay Stre	12. Was Decedent Armed Forces	Ever in U.S.	13. Was D	ecedent of Hi	spanic Origin? (S	Specify Yes or No	USA	14. Race - Ame Black, White	
336	n 72 hours after death with the Marylan *natural', or Items 23e or 28a-f ehow esical Examinat must be notified at	by Fui	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 I			es 2 No	Specify:	to moan, etc.,		Specify:	ack
21215-0036	72 hou natura	ted	15. Decedent's E (Specify only highest gi	Education	16a.	Decedent's	Usual Occupa	ation during most of wo	orkina	16b. Ki	ind of Business/	Industry
21		Completed	Elementary/Secondary (0-12)	College (1-4or	,	life. DO No	OT use retired)				
	Hygier Hygier ther th	Co	12th Grade 17. Father's Name (First, Middle, Las	1)	La	aborer		18 Mother's Na	me (First, Middle,		er King	
and	of the final Period of the	Be					-	Lucille		maidon	OBIII aliio)	
Maryland	s 1 and 2 should be filed withir F Heelth and Mental Hygiene. Item 27 is marked other than other traumatic event, ILA Ms	၉	Thomas E. Willia 19a. Informant's Name/Relationship		19b	Mailing Add			ural Route Number	er, City o	r Town, State, Z	Zip Code)
	nd 2 solith ar		Lucille Williams	. Mother	17	738 N.	Gay S	treet. E	altimore	. MI	21213	
Je,	os 1 a of Hee Item		20a. Method of Disposition		20b. Place of	Disposition		- +	Date		ocation - City or	Town, State
Ĕ	Page ment ant: If ury or		1		Trinit	ty Cem	•	9-2	9-05	Dund	lalk	
Baltimore,	permit. Pages 1 and 2 Depertment of Heelth a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Lice Gladys Warren				Polt	r.		. Ea	st 1101	E. North
			23a, Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	d the death. Do	not enter the	mode of dyin	more, MI g, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ations o	f Hype	rthyro	idism				Onset and Death
	/Medical		resulting in death)	a	s a consequence			·				
	Examiner		Sequentially list conditions,	b		4						
	pe tis	lne	cause. Enter Underlying Cause (Disease or injury	Dile to (or a	e a consuguence .	Oly						
•	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence	of):						
68760,	cate be execul physicien and the burial-tran	dical		. d								
_				V								
P.O. Box	law requires thet the death certifi as been signed by the attending 2 should be deteched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 □ Fetal death at time of death		oic pregnancy or (specify)				23d. Date of del Month	ivery Day Year
	res thet igned by be dete	by Pt	Part II. Other significant conditions	contributing to death	bul not resulting i	n the underly	ring cause give	en in Part I.	23e. Did t	obacco i	use contribute to	the cause of death?
rds	w require been sig should b								10	Yes 2̄	⊠ No 3 □ Pr	obably 4 Unknown
Division of Vital Records,	The law re ate has bei page 2 sho	Completed								osy omied?	prior to death?	lopsy findings available completion of cause of
tal	ian: Ti rtificate ctor, pa	e Co	25. Was case referred to medical					26. Place of De	ath (Check only o		MXYes	2 No
Ϋ́	Physician: r this certific ral director,	To B	examiner? 1∏Yes 2□ No	Hospital: 1 ☐ Inpat	ient 2XXER/Ou	tpatient 3[DDA Oth	er: 4 🗆 Nursing	Home 5 ☐ Resi	dence	6 ☐Other (Spe	cify)
0 4	ding Ph T. Alter th funeral		27. Manner of Death 1	28a. Date of In (Month, D	ury 28b.	Time of Injury	28c. Injun Wor		28d. Describe	how inju	ry occurred	
sio	Attending r death.	catl	2 Accident investigation 3 Suicide 6 Could not	L -		N		Yes 2 □ No	006 1	<u></u>	4. W t D.	De de Al Toba
) ivi	F 6 F C	Certification:	4 Homicide determine	d 289. Place of II	njury - Al home, fa atc. <i>(Specify)</i>	arm, street, fa	actory, office		City or To			ural Route Number,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C		Physician: To the bes aminer: On the basis and manner s	of examination an							
	o the	Me	29b. Signature and title of certifier	1	./		29c. Licens	e number		29d. Da	te signed (Monte	h, Day, Year)
	F > F 0			M. T.	1	ta	00	CME	5	Septe	ember 24	4, 2005
			30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type, Print)	1 D.	Ct	D 1		W 1	-1 01001
			mikarel	(Mi).				street	Baltimo	ore,	Maryla	na 21201
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. régis	Irar's Signature	Spece	Es .					

			1 - For State Registrar	State of Ma	aryland / Dep	ertificate of	Health a	ind Mental Hy	giene 0 0	5 31929
	Physici		1. Decedent's Name (First, Middle, La: Kandyce S	. Willia	ms			2. Date of De Month Septem	Day	Year 4: 22 A M
	/Medic Examin		4a. Facility Name (If not institution, give Sinai Hospita		Itimore		or Location of		4c. County	of Death
	Funeral Director		213-27-2418	D	(In yrs. last birthda 17 Yrs.	Months Day		Min. O 1 1	rth ay, Year) 1 88	Birthplace (State or Foreign Country) M D
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	e-f sh	ctor	MD NA		Baltimo	re				1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number	_		10f. Zip Code			10g. Citizen of W	
	s 23a	eral	3809 Byfield R	oad 12. Was Decedent B	Ever in U.S. 13	Was Decedent of	21207			S • A •
920	be filled within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28e-f show event, the Medical Examinar mint be notified at	by Funeral Director	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes XX If Yes, Give Year or Dates:	do	If Yes, specify Cu		in? (Specify Yes or No , Puerto Rican, etc.)	Black Specify:	k, White, etc.
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occ e kind of work don DO NOT use reti	supation ne during most	of working	16b. Kind of Bu	siness/Industry
121	within lene. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use reti udent	red)		Hig	h School
9	filed v Hygie other t		11th grade 17. Father's Name (First, Middle, Last)	na	51	udenc	18. Mother	r's Name (First, Middle		
Maryland	should be and Mental is marked o	To Be	James Grant				Cher	ly A. Win	nters	
ary	d 2 should be th and Menta 7 is marked traumatic ev) —	19a. Informant's Name/Relationship (Type, Print)				r or Rural Route Numb	-	
	D € Z E		Audrea Washing	ton-Guar				oad, Balt		
ore	S to I		20a. Method of Disposition 1 Surial 2 Cremation 3 □	Removal from State	20b. Place of Dis cemetery, cr	osition (Name of ematory or other p	lace)	Date	20c. Location -	City or Town, State
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify 21. Seattle of Funeral Service Licer	1	Marylar				Laurel	, Md
Ba	permit. Departr Importe any inju		1 thing a	11/20	Door 4	22. Name and Add larch F/	/H Wes	t ve, Balt:	imore,	Md 21215
	8		23a. Part1 Enter the disease, or com shock or heart failure. List only							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hune		ia and	1	rtension		Onset and Death
	/Medical		resulting in death)	Due to or s	a cons unce of):		١٠			2 1
	Examiner	Ļ	Sequentially list conditions, if any, leading to immediate		n negat	rive bo	ichere	mia		_ 3 days
	rted Insit	Examiner	Cause (Disease or injury	Parail	0.	a Once	imoni	itis		Iweek
á	te be executed ysician and he buriat-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequence of);	a			/	4 10
8760,	icate be executed physician and sthe buriat-transit	dlcal	(d CML	with w	rrelate	a bon	e marrow	Transipl	ant 2 months
Box 68	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetel death 3	□Ectopic pregnar			23d. Date	of delivery th Day Year
o.	at the de by the a tached f	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant at 9⊡ Unknown	time of death 5	Other (specify)				277445.00
Δ.	The law requires that the ate has been signed by the bage 2 should be detache	by Pł	Part II. Other significant conditions of							bute to the cause of death?
Records,	w require been sign		Thrombocytops	mia, ser	rere va	final k	needi	ng 10	Yes 2. No	3 ☐ Probably 4 ☐ Unknown
ecc	lawr nasbe 82sh	Completed						24a. Was	psy pi	fere autopsy findings available nor to completion of cause of eath?
al H								12 Yes	2 No 1	Yes 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpati	ent 3 DOA)th on	of Death (Check only of sing Home 5 Resi		r (Specify)
of	iding Phys th. : After this funeral di	77.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. In		28d. Describe	how injury occurre	
Division	ai or Attendi after death. I Director: A d in by the fu	Certification	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	iry - At home, farm, s :. (Specify)	treet, factory, offic	e	28f. Location (City or To		r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 12 Certifying Ph 2 Medicel Exam	ysician: To the best of niner: On the basis of and manner sta	examination and/or	ith occurred at the nvestigation, in my	time, date and y opinion, death	place, and due to the h occurred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
	To t To t	/	29b. Signature and title of certifier	Mickema		D	7712	8	Sep. 24	(Month, Day, Year)
1	N		30. Name and address of person who Charlotte Glicksh		240/ U	Jest Bel	lvedere	Ave. Br	eltimon	e, M.D. 21215
	Sta	ite	31. Date filed (Month, Day, Year)		r's Signature					
	Registr		OCT 0 3			Coule				
DH	WH 17 Hev 1/2	001		- 546	ORIGIN					
					Onlain	~ L				

		•	1 - For State Registrar	State of N	Marylar				ealth a				00	15	31930
	Physici	an	1. Decedent's Name (First, Middle, La		1ae			Wal:	ker		2. Date of De	25	у	2 [°] 6°05	3. Time of Death 4:00p M
	/Medi Examir		Dorothy 4a. Facility Name (If not institution, gire				4b. City		Location of	of Death				of Death	4.005
Ad Tool	Exami	iei is	Manor Care Nur				Bal	timo	re						
	Funeral Director		216-30-5440	Sex 7./ 1 ☐ M 2X F	Age (In yrs. 72	last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 04	rth a <i>y, Year)</i> .8	33	Cour	place (State or Foreign htry) ID
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City Limits
	Many Isah	to	MD NA		Ba]	ltimor	e:								1 XYes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zi	p Code				10g. Ci		What Cour	•
	23a c		4669 Falls Roa						209					S.A.	
Maryland 21215-0036	172 hours after deeth with the Maryland "naturel", or Iteme 23a or 28a-f show Alcal Examinatings the notified at	by Funeral	11. Marital Status 1 Never Married 2 Married **Midowed 4 Divorced	12. Was Deceder Armed Force 1 Tyes XI If Yes, Give Year or Dates	s?] No				spanic Ori n, Mexicar Specify:		cify Yes or Ne Rican, etc.)	0-		ck, White,	ean Indian, etc. .ack
5-0	"natu	etec	15. Decedent's E (Specify only highest gi				dent's Usu	al Occupa	ition lu <i>ring m</i> os)	t of workin	g	16b. K	and of Bu	usiness/In	dustry
121	withir ene. then	Completed	Elementary/Secondary (0-12) 9th grade	College (1-40	r 5+)				, rker			1	Fa	ctor	У
d 2	Hygi ther int,	BeCc	17. Father's Name (First, Middle, Las								(First, Middle	, Maider			
lan		To B	David Griswoul	ld					Lila	New	kirk				
lary	and and ie m		19a. Informant's Name/Relationship				-				Route Numb	-			
	an Beall The		Angetrette	-Daught					oad,		esteri				
Ore	5 0		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Removal from Sta	te (Place of Dispo cemetery, cre-	matory or	other place						•	own, State
Baltimore,			4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	-	1	Mt. Z:		nd Addres	s of Facilit	.0/1/	705	Ва	ITT	more	e, Md
Ba	permit. Departr Importe eny inj		XVMMIM	CARIL	MIH	Ma	arch	F/H	Wes	st	Balt:	imor	٠.	БМ	21215
-			23a. Paryl. Enter the disease, or cor shock, or heart failure. List only	nplications that caus	ed the deal								<u> </u>	IIG	Approximate Interval Between
1 2	Physician		Inmediate Cause (Final disease or condition	.0		some		Dee	lin	(Onset and Death
	/Medical		resulting in death)		as a consec		4		hin Dec	. 0 .					
п	Examiner		Sequentially list conditions, if any, leading to immediate	b. Ch	coro	m	Mer	<i>-</i>	Her	100	nt				
	ed sit	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2)	ca consec	0									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or									-		
8760,	siciar siciar e buri			-d. Hz	Anos	tenson	'n								
9	tificate t ig physic as the b	fedi			01										
.O. Box	The law requires that the death certificate be executed site been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al déath 3[∃Ectopic p ∃Other (s	oregnancy specify)						te of deliventh	ery Day Year
<u>α</u>	s that ned by deta	by Pt	Part II. Other significant conditions	contributing to death		-	ınderlying	cause give	n in Part I		23e. Did	tobacco	use cont	ribute to t	he cause of death?
rds	w requires been sign should be	ed b	Illnal trus	nla k	feed	en	10	1pe	17		10	Yes 2	□No	3 Prot	pably 4 Unknown
Vital Records,	law requas been 2 shoul	Completed									24a. Was		24b. \	Were auto	opsy findings available impletion of cause of
Ä		E O									perf	ormed? 2 ☐ No	_ (death? 1 Yes	
/ita	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	Handleh.				011			(Check only				
of \	Physic this c	2	1 Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatie			4 NL		ne 5 Res				(y)
LO	ding After fune	For	1 ⊟Natural 5 ☐ Pending	28a. Date of li (Month, I	Day Year)	Injury	м	28c. Injury Work	(? Yes 2 □		ou. Describe	now inju	ily occur	100	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At h etc. (Speci	nome, farm, st	reet, facto	ry, office		2	8f. Location City or To			er or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical ((Check only 2 Medical Exa	hysician: To the beaminer: On the basis	of examina										
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier	and manner	stated.		25	9c. License	number			29d. Da	ite signe	d (Month,	Day, Year)
	F 3 F 8		· Dau	Int	-	MD	1		146	4		9	12	410	5
١	1 ev		30. Name and address of person who	completed cause of	f death (Ite	m 23a) (Type.	Print)			~ ~	0		1		-
1	1		SHOAIIS A. H	HHM1 r		8211	J. EL	MAV	V 51	for	te-30	f,	BA	CTIF	nuce mo
9	St. Regist	ate rar	31. Date filed (Month, Day, Year)		smars Sign	ature	La	Si s							21601

68760,
Вох
P.O.
Records,
Vital
o
Division

			Please 7	ype or Print State of Mar				•	_	ble.
			For State Registrar	Otate of Ivial		rtificate of			Reg. No 20	05 31931
	0 1		Decedent's Name (First, Middle, Last)					2. Date of De. Month		3. Time of Death
1	Physici /Medio				M. White			SEPTEMB	ER 21, 2	2005 12NOON M
7	Examir	er	4a. Facility Name (If not institution, give : 3919 Duvall At	street and number)		_	or Location of Death		4c. County	of Death
	Funeral Director		5. Social Security Number 6. Sec	7. Age (In yrs. last birthday, 5 Yrs.		If Under 24 Hrs.	8. Date of Bird (Month, Da	th y, Year)	Birthplace (State or Foreign Country) Md
	P .		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or L	ocation				10d. Inside City Limits
	Manylia -f aho	tor		I/A	Balto					17 Yes 2 ☐ No
	or 28e	Director	10e. Street and Number			10f. Zip Code	21216		10g. Citizen of V	What Country?
	a 23a	ral	3919 Duvall Avenu	Le 12. Was Decedent Ev	- II C 42			and Van as No	U S A	A e - American Indian,
396	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28e-f ahow thit, the Medical Examinat must be multied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		was Decedent or r If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, etc.
2-0	72 hou	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occup	pation during most of work	sina	16b. Kind of Bu	usiness/Industry
21215-0036	be filed within 72 hours hat Hygiene. od other than "natural", avant, the Medical Exa	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) 4 year	Cupo	DO NOT use retire rvisor	during most of work d)		Sweetl	neart Cup Co.
	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)	- year	<u> </u>		18. Mother's Nam	e (First, Middle,	Maiden Surnam	ne)
yla	2 should be and Mental Is marked o	To	Marion White					e White		
Maryland	s 1 and 2 should if Heelth and Men item 27 is marke other traumatic	18	19a. Informant's Name/Relationship (Ty Beverly White - Wi	•		ng Address (Street L Windy O	and Number or Rur ak Ct Cr		er, City or Town, Md 21114	
αĵ	of Heelth item 27 other tr		20a. Method of Disposition		20b. Place of Dispe			Date	20c. Location -	City or Town, State
imo	Page ment c ant: If ury or		1 Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Md Nat Me			-2005	Laurel,	, Md
Baltimore,	permit. Pages of Depertment of Inportant: If Ite any Injury or of Once.		21. Signature of Funeral Service Licens	* 4.	2	2. Name and Addre	Ma	rch F/H		
			23a. Part 1 Enter the bisease, or compli	cations that caused th	e death. Do not en		bash Aven ng, such as cardiac			Approximate
1	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	Te cause on each line.	is Arter	y Diseas	K			Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a c						LOVEAUS
	% "	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a		4 years				
	be executed cien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hyperl		4 years				
60,	be exe	I I		Due to for as a c	ohsequence of):					
09289	rtificate being physici	ledic								
Вох	ath cert attendin for use	Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2 (Fetal death 3	Ectopic pregnanc	у		23d. Dat Moi	e of delivery nth Day Year
P.O.	by the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne or death 5L	Other (specify) _			Aug I	
	es the	ρ	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	inderlying cause giv	ven in Part I.			ribute to the cause of death?
of Vital Records,	law requir es been s 2 should	Completed						24a. Was	an 24b. V	Were autopsy findings available office to completion of cause of
E		Con							rmed?	death? ☐ Yes 2 ☐ No
Vita Vita	Physician: The this certificate al director, par	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	2 ER/Outpatier	nt 3□ DOA Ott	26. Place of Deat ner: 4 ☐ Nursing Ho	-	<i>ne)</i> dence 6 ⊟Othe	or (Engelie)
ion of	ding h. After fune	-	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time o	of 28c. Inju			now injury occurr	
Division	el or Attendi s after death. il Diractor: A ad in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (reet, factory, office		28f. Location (5 City or Tow		er or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dire completely filled in b	edical ((Check only one) Cartifying Physical Cartifying Physical Examin	nician: To the best of r ner: On the basis of ex and manner state	camination and/or in	h occurred at the tile exestigation, in my o	ne, date and place opinion, death occur	and due to the tred at the time, o	date and place, a	and due to the cause(s)
	To the within 2 To the complet	7	29b. Signature and title of certifier	DV)		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	1/1		David ours,	W	1000					ER 23, 2005
_	2			dere Ave	nue, Sui	Print) 1622 B	saltimore,	MD 21	215	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 3 2	32. Registrar's		Sparte.				

			State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and Mertificate of Death		ne 2005 31932
	Physicia		1. Decedent's Name (First, Middle, Last) Donald Leroy Warren, Jr.		2. Date of Death Month Septemb	Day Year er 25,2005 9:00P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Бересии	4c. County of Death
	Funeral		1014 Dalton Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Dundalk If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	Baltimore 9. Binthplace (State or Foreign Country)
	Director		217-19-8948 1⊈ M 2□ F 27 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Dec. 23,	1977 Maryland
	yland how		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	he Mar 8a-fel	Director	Maryland Baltimore	Dundalk	100	2. Citizen of What Country?
	3a or 2	Dir	1014 Dalton Avenue	21224	105	United States
213-0030	should be lied within 72 hours atter deeth with the maryland and Mental Hygiene. "Hygiene" the "Hygiene" marked other then "netural", or items 23a or 28a-f ehow marked other then "netural", or items 23a or 28a-f ehow matic event, the Madical Examiner must be notilied at	by Funeral	11. Marital Status 1	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 № No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
		Completed	15. Decedent's Education 16a. Dec (Giv.	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 16	Sb. Kind of Business/Industry
777	iled wil		N/A 17. Father's Name (First, Middle, Last)	Dependent 18. Mother's Name	e (First, Middle, Ma	N/A uiden Sumame)
	outd be filed with Mental Hygiene. Brked other ther atic event, the N	To Be	Donald L. Warren, Sr.		y A. Benn	
Mary	12 should in and Men 7 is marke		Toda tillottidition tallion to the control of the c	ling Address <i>(Street</i> and Number or Rura 14 Dalton Ave. Dur	al Route Number, 0 ndalk, Ma	
5	s 1 and if Health item 27 other to		20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or Town, State
Saitimor	permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 is marke any injury or other treumatic.	1			9/2005	Towson, Maryland
Dan	Depermit Depermit Import any In		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ouda-Ruck Funeral I 7922 Wise Ave. Dur	Home of D ndalk, Ma	undalk, Inc. ryland 21222
		J	23a Part. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	or respiratory arres	t, Approximate Interval Between Onset and Death
â	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	my anest		
	Examiner	7.0	Sequentially list conditions, day, leading to immediate b. Due to (or as a consequence of):	Hal palsey.	* Se	izure
p	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		ac	sorder
9/90,	icate be executed physicien and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of): d.			
Õ	ertificat ling phy e as th	Medi	IF FEMALE: 230 If use systems of programs			COA Data of Addison
or vital Rec	the death certificate be the attending physicie iched for use as the bu	d by Physician/Me		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	requires that the der wen signed by the a hould be detached t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □Unknown
	To the Hospitel or Attending Physician: The law requir within 24 hours alter death. To the Funerel Director: After this certificate hes been si completely filled in by the funeral director, page 2 should!	Completed			24a. Was an autopsy performe	
		edical Certification; To Be Co	25. Was case referred to medical examiner?		1 ☐ Yes 2 8 h (Check only one)	
			1 ☐ Yes 2≅ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time Injury (Month, Day Year)	of 28c. Injury at Work?	me 5 ⊠Residen 28d. Describe how	ce 6 Other (Specify) rinjury occurred
			2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 □ Yes 2 □ No	28f. Location (Stre City or Town,	net and Number or Rural Route Number, State)
			29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e. Print)	> /	7/27/05
_		2	Yoon Kum 9114 Philadelphia Road		re, Mary	land
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ash I		

5-40-0805 Residence of Decedent State 10b. County	7. Age 2 F 7. Age 10	20b. Place cemel Metro	birthday) Yrs. Dundalk 101. Zi 13. Was Dece If Yes, spe 1 Yes 6a. Decedent's Usu (Give kind of willide. DO NOT to 18.	ip Code 1222 adent of Hispan script Cuban, Me 2CXNo Sp ual Occupation or done during use retired) ian 18.1 H. ss (Street and A r ling A are of or of place) Dry and Address of the companion in the companion of the compani	John 24 Hrs. Jours Min	ecify Yes or No-Rican, etc.) ing ing ing ing ing Mc Will al Route Number Baltim Cate / 2005 Funeral Baltimor	4c. County of Deal A A 9. Birl 20, 1943 10g. Citizen of What Co USA 14. Race - Ame Black, Whit SpecifyWhi 16b. Kind of Business Self Empl Maiden Sumame) 1iams 7. City or Town, State, 2 20c. Location - City or atonsville Home, Ince, Marylane	thplace (State or Fore punity) Maryland 10d. Inside City Limit 1 Pes 22 1 Perican Indian, e., etc. te Vindustry oyed Zip Code) and 21211 Town, State , Maryland
State 10b. County ryland Balt State 10b. County ryland Balt Street and Number D Villager Cir farital Status □ Never Married 2□ Marrie Styling My Highest (Specify only highest rementary/Secondary (0-12) 6 Alvin Wiles Informant's Name/Relationshi Γanya Bloom Method of Disposition □ Burial 200cremation 3 □ □ Donation 5□ Other (Specify only highest in the disease, or condition integral ase or condition rentially list conditions, the leading to immediate ase or condition integral plosesse or injury initiated events	ip (Type, Print) Daughter 3 □ Removal from State ecity) icensee b. Due to (or as a c.	10c. City, To	Months www.or.Location Dundalk 101. Zi 21 13. Was Deceder 11 Yes 6a. Decedent's Usu (Give kind of No No Ti Electrici 9b. Mailing Addres 1314 Mor of Disposition (Na Nery, crematory or o Cremato 22. Name a Burgee 3681	ip Code 1222 adent of Hispan script Cuban, Me 2CXNo Sp ual Occupation or done during use retired) ian 18.1 H. ss (Street and A r ling A are of or of place) Dry and Address of the companion in the companion of the compan	Juder 24 Hrs. Juris Min. Sic Origin? (Sp. exican, Puerlo existen, Puerlo existen g most of work Mother's Name elen venue, 9/15/ Facility Seitz Road, F	ecify Yes or No-Rican, etc.) ecify Yes or No-Rican, etc.) ing e (First, Middle, Mc Will al Route Number Baltime) Cate / 2005 Funeral Baltimor	9. Birlow 200, 1943 10g. Citizen of What Could USA 14. Race - Ame Black, White Specify Whi 16b. Kind of Business. Self Emplomaiden Sumame) 11ams 17. City or Town, State, 200c. Location - City or Catonsville Home, Ince, Marylane	Maryland 10d. Inside City Limi 1 Yes XXIII Duntry? encan Indian, e, etc. te Industry Oyed Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
State 10b. County ryland Balt State 10b. County ryland Balt Street and Number D Villager Cir farital Status □ Never Married 2□ Marrie Styling My Highest (Specify only highest rementary/Secondary (0-12) 6 Alvin Wiles Informant's Name/Relationshi Γanya Bloom Method of Disposition □ Burial 200cremation 3 □ □ Donation 5□ Other (Specify only highest in the disease, or condition integral ase or condition rentially list conditions, the leading to immediate ase or condition integral plosesse or injury initiated events	ip (Type, Print) Daughter 3 □ Removal from State ecity) icensee b. Due to (or as a c.	10c. City, To	Months Dundalk 101. Zij 21 13. Was Dece If Yes, spe 1 □ Yes 6a. Decedent's Usu (Give kind or NoTi iffe. DO NOTi Electrici 9b. Mailing Addres 1314 Mor of Disposition (Na 18ery, cramatory or of Cremato 22. Name a Burgee 3631 Do not enter the mo	ip Code 1222 adent of Hispan early Cuban, Me 2CXNo Sp ual Occupation ork done during use retired) ian 18.1 Hiss (Street and A rling A arme of other place) ory und Address of telephones Falls ide of dying, suc	ic Origin? (Spexican, Puerlo exican, Puerlo exican, Puerlo exity: Mother's Name elen Number or Run Venue, 9/15/ Facility Seitz Road, F	ecify Yes or No-Rican, etc.) ecify Yes or No-Rican, etc.) ing e (First, Middle, Mc Will al Route Number Baltime) Cate / 2005 Funeral Baltimor	10g. Citizen of What Course USA 14. Race - Ame Black, White Specify White 16b. Kind of Business. Self Emplowed Maiden Sumame) Liams r. City or Town, State, 200c. Location - City or Satonsville Home, Ince, Marylane, Marylane, Marylane	Maryland 10d. Inside City Limi 1 Yes XXIII Duntry? encan Indian, e, etc. te Industry Oyed Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
State 10b. County ryland Balt Street and Number D Villager Cir larital Status Never Married 2 Marrie Stylicowed 4 Divorced 15. Decedent's (Specify only highest mentary/Secondary (0-12) 6 Alvin Wiles Informant's Name/Relationshi Tanya Bloom Method of Disposition Burial 200cremation Burial 200cremation Cignature of Fuheral Service List of Secondary (1) Partl. Enter the disease, or coshock, or heart failure. List of Secondary (1) Partl. Enter the disease or condition Interpretation of the secondary (1) Partl. Enter the disease or condition Interpretation of the secondary (1) Partl. Enter the disease or condition Interpretation of the secondary (1) Partl. Enter the disease or condition Interpretation of the secondary (1) Partl. Enter the disease or condition Interpretation of the secondary (1) Partl. Enter the disease or conditions (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease or condition (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Partl. Enter the disease (1) Part	12. Was Decedent E Armed Forces? 1	20b. Place cemel Metro	Dundalk 10f. Zij 23 13. Was Decelli Yes, spe 1 Yes 6a. Decedent's Usus (Give kind of wind) (iffe. DO NOTE Electrici 9b. Mailing Addres 1314 More of Disposition (Na otery, crematory or of Crematory Crematory on of Disposition (Na otery, crematory or of Disposition (Na otery, crematory or of Disposition (Na otery, crematory or of Disposition (Na otery, crematory or of Disposition (Na otery, crematory or of Disposition (Na otery, crematory or of Disposition (Na otery, crematory or)	addent of Hispan ecity Cuban, Me aCXNo Sp ual Occupation ork done during use retired) ian 18. i Hiss (Street and N r ling A ame of other place) ory und Address of teleplaces Falls ide of dying, sui	most of work Mother's Name elen Number or Run venue, 9/15/ Facility —Seitz Road, F	ecity Yes or No-Rican, etc.) ing e (First, Middle, Mc Will al Route Numbe Baltim Date / 2005 C	USA 14. Race - Ame Black, White Specify Whi 16b. Kind of Business Self Emplomaiden Sumame) Liams r. City or Town. State. 200c. Location - City or atonsville Home, Ince, Marylane, Marylane	1 □ Yes X2X Nountry? sincan Indian, e, etc. te //industry oyed Zip Code) and 21211 Town, State Maryland 21211 Approximate Interval Between
Street and Number O Villager Cir arital Status Never Married 2 Marrie Never Married 2 Marrie (Specify only highest breentary/Secondary (0-12) 6 Alvin Wiles Informant's Name/Relationshi Fanya Bloom Method of Disposition Burial 2000 Cremation Burial 2000 Cremation Cignature of Fuheral Service List of ediate Cause (Final ase or condition ting in death) Intentially list conditions, leading to immediate e. Enter Underlying to [Disease or injury initiated events]	12. Was Decedent E Armed Forces? 1	20b. Place cemet Metro the death. Does.	13. Was Decedent's Usu (Give kind of wilder DO NOT LE CTRICE) 9b. Mailing Addres 1314 More of Disposition (National Control of Cremator) 22. Name a Burgee on ontended the mode of the m	addent of Hispan ecity Cuban, Me aCXNo Sp ual Occupation ork done during use retired) ian 18. i Hiss (Street and N r ling A ame of other place) ory und Address of teleplaces Falls ide of dying, sui	most of work Mother's Name elen Number or Run venue, 9/15/ Facility —Seitz Road, F	ecity Yes or No-Rican, etc.) ing e (First, Middle, Mc Will al Route Numbe Baltim Date / 2005 C	USA 14. Race - Ame Black, White Specify Whi 16b. Kind of Business Self Emplomaiden Sumame) Liams r. City or Town. State. 200c. Location - City or atonsville Home, Ince, Marylane, Marylane	pointry? prican Indian, e, etc. te //industry oyed Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
arital Status □ Never Married 2□ Marrie ■ Never Married 2□ Marrie ■ Never Married 2□ Marrie ■ Never Married 2□ Marrie ■ Status □ 15. Decedent's □ Specify only highest □ Information Name/Relationship □ Alvin Wiles □ Informant's Name/Relationship □ Burial 20℃ remation □ □ Burial 20℃ remation □ □ Donation □ □ Other (Specification of the properties) □ Donation □ □ Other (Specification of the properties) □ Part1. Enter the disease, or condition □ Inter Inderty the disease of condition of the properties of the propert	12. Was Decedent E Armed Forces? 1 Yes 22 N If Yes, Give Year or Dates: S Education Grade completed) College (1-4or 5-4) ast) ip (Type, Print) Daughter 3 Removal from State ecity) idensee complications that caused anity one cause on each lim a. Sep. Due to (or as a complete of c	20b. Place cemel Metro	13. Was Deceler If Yes, specify yes, yes, yes, yes, yes, yes, yes, yes	addent of Hispan ecity Cuban, Me aCXNo Sp ual Occupation ork done during use retired) ian 18. i Hiss (Street and N r ling A ame of other place) ory und Address of teleplaces Falls ide of dying, sui	most of work Mother's Name elen Number or Run venue, 9/15/ Facility —Seitz Road, F	ecity Yes or No-Rican, etc.) ing e (First, Middle, Mc Will al Route Numbe Baltim Date / 2005 C	USA 14. Race - Ame Black, White Specify Whi 16b. Kind of Business Self Emplomaiden Sumame) Liams r. City or Town. State. 200c. Location - City or atonsville Home, Ince, Marylane, Marylane	erican Indian, e, etc. te //Industry oyed Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
Alvin Wiles Informant's Name/Relationshi □ Donation □ Donation □ Other (Specify or heart failure. List of each assert or conditions, lentially list list list list list list list list	12. Was Decedent E Armed Forces? 1 Yes 22 N If Yes, Give Year or Dates: S Education Grade completed) College (1-4or 5-4) ast) ip (Type, Print) Daughter 3 Removal from State ecity) idensee complications that caused anity one cause on each lim a. Sep. Due to (or as a complete of c	20b. Place cemel Metro	13. Was Deceil I'Yes, spending to the property of the property	adent of Hispan serity Cuban, Me 2CXNo Sp ual Occupation ork done during use retired) ian 18.1 H. ss (Street and A rling A ame of orther place) ory and Address of the Carlis Falls ide of dying, sue	most of work Mother's Name elen Number or Run venue, 9/15/ Facility —Seitz Road, F	ing ing ing ing ing ing ing ing	14. Race - Ame Black, Whit SpecifyWhi 16b. Kind of Business Self Emplomaiden Sumame) Liams r. City or Town, State, 200c. Location - City or atonsville Home, Ince, Marylane, Marylane	e, etc. te Andustry oyed Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
Never Married 2 Married Widowed 4 Divorced 15. Decedent's (Specify only highest rementary/Secondary (0-12) 6 Alvin Wiles Informant's Name/Relationshi Fanya Bloom Method of Disposition Burial 2 Coremation Donation 6 Other (Specify only highest) Gignature of Fuheral Service Lie Part 1. Enter the disease, or c shock, or heart failure. List of secondary of the condition liting in death) Pentially list conditions, (, leading to immediate e. Enter Underlying e. (Disease or injury initiated events)	ast) In the series of the ser	20b. Place cemet Metro the death. Do	1 □ Yes 6a. Decedent's Usu. (Give kind of wind ide. DO NOT use) 9b. Mailing Addres 1314 More 1314 More 1314 More 1314 More 22. Name ase 33836 22. Name ase 33836 24. Name ase 25. Name ase 26. Name ase 27. Name ase 28. Name ase 29. Name ase 29. Name ase 20. not enter the more	ame of other place) Dry and Address of depths Falls General Address of depths The place of dying, sude of	most of work mother's Name elen number or Run venue, 9/15/ Facility —Seitz Road, F	ing Mc Willal Route Number Baltim Date /2005 Funeral Baltimor	SpecifyWhi 16b. Kind of Business Self Empl Maiden Surname) liams r. City or Town. State. 2 20c. Location - City or atonsville Home, Ince, Marylane, Marylane	Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
Is. Decedent's (Specify only highest (Specify only highest ornentary/Secondary (0-12) 6 ather's Name (First, Middle, Lichard Name/Relationship on the control of the contr	Year or Dates: s Education grade completed) College (1-4or 5-4) ip (Type, Print) Daughter 3 □Removal from State ecity) icensee complications that caused inty one cause on each line a. Due to (or as a college) Due to (or as a college)	20b. Place cemet Metro	9b. Mailing Addres 1314 Mor of Disposition (Na otery, crematory or o Cremato 22. Name a Burgee bo not enter the mo	ian (Street and A rling A rame of other place) ory and Address of the STAILS raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and A raise of dying, such as the street and the street	Mother's Name elen Number or Run venue, 9/15/ Facility Seitz Road, F	Mc Wilas Route Number Baltim 2005 Funeral Baltimor	Self Emple Maiden Surmarne) Lliams r, City or Town, State, 2 20c. Location - City or Catonsville Home, Ince, Marylane	Oyed Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
(Specify only highest smentary/Secondary (0-12) 6 Alvin Wiles Informant's Name/Relationship Tanya Bloom Method of Disposition Burial 2020 cremation (Specific Partial Partial Enter the disease, or condition ting in death) Partil Enter the disease, or condition ting in death) mentially list conditions, (Leading to immediate elements or injury mitiated events	ip (Type, Print) Daughter 3 □Removal from State ecify) icensee complications that caused only one cause on each line a. 5 € p. Due to (or as a c.	20b. Place cemet Metro	Give kind of willing. DONOTE Electrici 9b. Mailing Addres 1314 More of Disposition (Na atery, crematory or o Crematory 22. Name a Burgee bo not enter the mo	ian Is. is (Street and A rling A other place) ory and Address of the place of the place of dying, such as the d	Mother's Name elen Number or Run venue, 9/15/ Facility Seitz Road, F	Mc Wilas Route Number Baltim 2005 Funeral Baltimor	Self Emplomaiden Surname) Lliams r. City or Town. State. 2 20c. Location - City or atonsville Home, Ince, Marylane	Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
Alvin Wiles Alvin Wiles Informant's Name/Relationshi Tanya Bloom Method of Disposition Burial 2000 Cremation of Other (Special Council) Burial 2000 Cremation of Other (Special Council) Part 1. Enter the disease, or coshock, or heart failure. List of special council counc	ip (Type, Print) Daughter 3 □ Removal from State ecity) icensee complications that caused only one cause on each lim a. Sep. Due to (or as a b. Due to (or Maa)	20b. Place cemel Metro the death. Does a consequence	9b. Mailing Addres 1314 Mor e of Disposition (Na etery, crematory or o Cremato 22. Name a Burgee 3631 Do not enter the mo	He ses (Street and A rling A of other place) Ory and Address of the place of other place) Talls ide of dying, such	elen venue, 9/15/ Facility —Seitz Road,	Mc Wil	Maiden Surname) liams r, City or Town, State, 2 ore, Maryla 20c. Location - City or atonsville Home, Inc e, Marylane	Zip Code) and 21211 Town, State , Maryland 21211 Approximate Interval Between
Alvin Wiles Informant's Name/Relationshi Tanya Bloom Method of Disposition Burial 2X Cremation Donation Gother (Spe Signature of Fuheral Service Li Part 1. Enter the disease, or c shock, or heart failure. List of section of the condition ting in death) Pentially list conditions, (, leading to immediate e. Enter Underlying e. (Disease or injury nitiated events	ip (Type, Print) Daughter 3 □ Removal from State ecity) icensee complications that caused only one cause on each lim a	20b. Place cemet Metro	1314 More of Disposition (Na Mery, crematory or o Crematory or o Crematory or o Burgers and Burgers on onto enter the more of):	Hose (Street and Arling Arling Arling Arling Arling Arling) Ory and Address of the Palace Falls ide of dying, such	elen venue, 9/15/ Facility —Seitz Road,	Mc Wil	liams r, City or Town, State, 2 tore, Maryla 20c. Location - City or atonsville Home, Inc e, Marylan	and 21211 Town, State , Maryland 21211 Approximate Interval Between
Informant's Name/Relationship Tanya Bloom Method of Disposition Burial 200 cremation of Donation of	Daughter 3 □Removal from State ecify) idensee complications that caused inly one cause on each line a	20b. Place cemet Metro	1314 More of Disposition (Na Mery, crematory or o Crematory or o Crematory or o Burgers and Burgers on onto enter the more of):	ss (Street and A rling A ame of other place) ory and Address of the Henss Falls add of dying, such	venue, 9/15/ Facility Seitz Road,	Baltimore Sumber Baltimore Summer Baltimore Ba	r, City or Town, State, 2 lore, Maryla 20c. Location - City or atonsville Home, Inc e, Marylan	and 21211 Town, State , Maryland 21211 Approximate Interval Between
Method of Disposition Burial 20 Cremation Comments Donation 6 Other (Special Service Libert Comments) Part1. Enter the disease, or coshock, or heart failure. List of ediate Cause (Final ase or condition liting in death) Tentially list conditions, (leading to immediate e. Enter Underlying to [Disease or injury initiated events]	a	the death. Done.	o of Disposition (Natery, crematory or or or or or or or or or or or or or	ame of other place) Ory and Address of the place Falls ide of dying, such	9/15/ Facility Seitz Road,	72005 C Funeral Saltimor	20c.Location-City or atonsville Home, Inc e, Marylan	Town, State , Maryland 21211 Approximate Interval Between
Burial 20 Cremation Donation G Other (Spe Signature of Fuheral Service Li Part 1. Enter the disease, or c shock, or heart failure. List of sale or condition ting in death) rentially list conditions, (, leading to immediate e. Enter Underlying e) (Disease or injury nitiated events	icensee complications that caused inly one cause on each line a	the death. Done.	o Crematory or or or or or or or or or or or or or	other place) Ory and Address of the Tails ide of dying, such	9/15/ Facility Seitz Road, F	/2005 C Funeral Saltimor	atonsville Home, Inc e, Marylan	, Maryland 21211 Approximate Interval Between
Part1. Enter the disease, or c shock, or heart failure. List of editate Cause (Final ase or condition liting in death) rentially list conditions, (, leading to immediate e. Enter Underlying e) (Disease or injury nitiated events)	complications that caused inly one cause on each line. a	the death. Do	22. Name a Burge 6 36 91 co not enter the mo	and Address of EHENSS FaIIS Jude of dying, suc	Facility -Seitz Road, E	Funeral Baltimor	Home, Inc e, Marylan	21211 Approximate Interval Between
Part1. Enter the disease, or c shock, or heart failure. List of ediate Cause (Final ase or condition ting in death) sentially list conditions, (, leading to immediate e. Enter Underlying to (Disease or injury nitiated events)	a. Due to (or as a c.	5:5 a consequence	Burges So not enter the mo	EHENSS Falls de of dying, su	Road, I			Approximate Interval Between
shock, or heart failure. List of ediate Cause (Final ase or condition (ting in death) rentially list conditions, (, leading to immediate e. Enter Underlying e) (Disease or injury initiated events	a. Sep. Due to (or as a Due to (or as a c.	5:5 a consequence	ce of):	ode of dying, su				Approximate Interval Between
ediate Cause (Final asse or condition liting in death) Hentially list conditions, (), leading to immediate (). Enter Underlying () initiated events	a. Sep. Due to (or as a b. Due to (or as a c.	5.5 a consequence	periton	itis				Unset and Death
ientially list conditions, ,, leading to immediate e. Enter Underlying e (Disease or injury nritated events	b. Due to (or as a	901	periton	:115				/
y, leading to immediate e. Enter Underlying se (Disease or injury nitiated events	c			1113				* 1.u.
nitiated events	c							J 4 2 4 3
(iiig iii dodiii) Last								
	Due to (or as a	a consequence	ce or):					
	d							
MALE: Was decedent pregnant	23c. If yes, outcome of 1 □ Live birth			pregnancy			23d. Date of del Month	livery Day Year
in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t 9□Unknown	time of death	5 ☐ Other (s	specify)			11101111	54)
I. Dther significant condition	ns contributing to death bu	ut not resulting	g in the underlying	cause given in	Part I.	23e. Did to	bacco use contribute to	the cause of death?
						1 🗆 Y	es 2⊠No 3□Pr	obably 4 Unknow
						24a. Was autop	sy prior to	utopsy findings availat completion of cause of
						perfor 1 X Yes	med? death? 2□No 1□Yes	2 ™ No
Vas case referred to medical xaminer?	Hospital:	- a 🗆 E D (C	Outpationt 2 D					cifu)
lanner of Death	28a. Date of Injury	ry 28b						ony,
Accident investiga	ation	, , , , ,	M					
Homicide determin	nod 200. Flace of iliju	ury - At home, c. (Specify)	, farm, street, facto	nry, office		28f. Location (S City or Tow	itreet and Number or Ri m, State)	ural Route Number,
(Check only 2 Medical E					n, death occur			
Signature and title of certifier			29	9c License nun			29d. Date signed (Mont	
B/ my 4	~ Ph.D., M.L	Λ		2 55-0			September	
4	aminer? Yes 2 No anner of Death Natural 5 Pending investig Suicide 6 Could n determi Certifier 2 Medical E Signature and title of certifier	Accident Suicide Hospital: 1 Month, Day	Accident Suicide Homicide Accident Contifier (Check only one) Accident Continuous one) Accident Continuous one) Accident Continuous one) Accident Continuous one Accident Continuous one Accident Accident Suicide Accident Acci	Accident Suicide Hospital: Month, Day Year) Suicide Homicide Accident Suicide Homicide Accident Suicide Homicide Accident Suicide Homicide Accident Suicide Homicide Accident Suicide Accident Suicide Homicide Accident Suicide Accident Suicide Homicide Accident Suicide Accident Suicide Accident A	Accident Suicide Hospital: Image: Accident Suicide Homicide Accident Suicide Homicide Accident Suicide Accident Suicide Accident Suicide Accident Suicide Accident Accident Suicide Accident Suicide Accident Suicide Accident Accident Accident Accident Suicide Accident A	Accident Suicide Homicide Accident Suicide Homicide Accident Cortifier (Check only one) Accident Cortifier (Check only one) Accident Cortifier one) Accident Cortifier one) Accident Cortifier one) Accident Cortifier one) Accident Cortifier one) Accident Cortifier one) Accident Cortifier one) Accident Cortifier one) Accident Accident Cortifier one) Accident	Accident	Accident Suicide Homicide

State of Maryland / Department of Health and Mental Hygiene Reg. No. 005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 30, 2005 **Physician** 2:20P F. WILLIAM ZORZI /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 114B East Melrose Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 1924 | 192 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania 1 XX 2 F Yrs. 80 199-12-3818 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle item 27 is marked other than "natural; or items 23a or 28a-f ebov other treumatic event, the Natical Examinar institutes in cliffied at XXYes 2 No Director Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 USA 114B East Melrose Avenue death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ar N No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or iten any injury or other treumatic event, the Madical Exemplem 2000. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Auto Club 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Elizabeth Robinson Zorzi Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 114B East Melrose Avenue Baltimore Maryland 21212 Mary Fannon Zorzi Wife 20a. Method of Disposition

1XXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) New Cathedral Cemetery 10/4/05 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. gnature of Funeral Se 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 mart Gaskointestnul bleedin **Physician** /Medical Due to (or as a consequence of): Examiner Colitis ulcera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Alzherman's type (pallietive core physicien and the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificete has been signi rector, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Contitying Physician: To the best of my knowledge desth oncurred at the time date and place, and due to the dausets) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier To the Hosp wi hin 24 hou To the Fune completely fi (Check only one) Medi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of confider death (Item 23a) (Type, Print) Pool Sulo 200 Lutharull 30. Name and address of INO. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 31935 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9/15/2005 Ahmad Amini 0220 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 5/5/1955 **Funeral** Birthplace (State or Foreign Country) 214-41-6250 1**⊠**M 2□F Months Days Hours 50 Director Afghanistan Usual Residence of Decedent the Maryland 10a. State rel', or items 23a or 28e-f ehow Examinatival benefitted at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Md. Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2417 White Horse St. 20906 Afghanistan Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Yes 2 XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Specify: asian "naturel" Year or Dates: Completed other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) Operations Manager Catering Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Inportant: If item 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Gulam Nabi Amini Hwa Amini ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Barin Amini/ daughter 3344 Hewitt Ave. Apt#80 Silver Spring, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐Donation 5 ☐ Other (Specify) George Washington 9/18/2005 Adelphi, Md. 21. Signature of Buneral Service Lice 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC 20011 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Anoxic Encephalopathy /Medical Due to (or as a consequence of): Examiner Hanging Sequentially list conditions, if any, leading to immediate cause. Entail Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the death certificate be executed as the burial-transit Suicide that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year P.O. I 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ The law requires pe Pontine Hemorrhage 1 Yes 2 No 3 Probably 4 Unknown Completed has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Division of Vital 1 Yes 2 X No 1 ☐ Yes 2 X No Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospital: J_o 11X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Hospitel or Attending After 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

I Director: Af
d in by the fu P.M. 8/9/2005 2 Accident 1 Yes 2 No Hanging-Suicide(ligature 6 ☐ Could not be 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver determined 4 Homicide home within 24 hours a

To the Funerel C

completely filled 417 White Horse Ln.Spring Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 015239 9/16/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl I. Margolis, MD 11125 Rockville Pike, Rockville, Md. 31. Date filed (Month, Day, Year) State SEP 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** September 6, 2005 5:30 A M Edmond William Anastasi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Calvert County Nursing Center Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Nov. 11, 1916 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₩ 2□F 578-12-6891 Pennsylvania 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Calvert County Prince Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20678 U.S.A. 238 125 Allnut Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Local Union #1 Brick Mason 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Placid Anastasi Theresa Reggi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a lant: If itsm 27 b 4065 Willows Road, Chesapeake Beach, MD 20732 Edmond G. Anastasi (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept Date 12. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department Important: If any injury or once. 2005 Falls Church, Virginia National Mem. Park 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fundamental State of S Michael W. 1 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART /Medical Due to (or as a consequence of): Examiner REGUNG 17 AORTIC Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed ed by the attending physician and detached for use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 4 Unknown 2 🗆 No 3 Probably Completed LYMPHOCYTIC LEVELTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; or Attending 1 atural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 050233 110 NOSPIME DRIVE, SVITE 307 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glynis 31. Date filed (Month, Day, Year) 32. Registr#s Signature State SEP 0 9 2005 Registrar

			For State Registrar	licuc	State of	Marylar	nd / Depa	artmen rtificate	t of H e of L	ealth a	and M	ental H	ygiene Reg. No.	2005	31937
	Physici /Medic		1. Decedent's Nam Janie I	e (First, Middle,								2. Date of Month	Day	Year 2005	3. Time of Death
	Examir		,		give street and numb	oer)		,		Location of		-		County of Dea	ith
	Funeral Director		5. Social Security N 230-50-7	Number		Age (In yrs. 92	last birthday) Yrs.			If Under Hours		8. Date of 1 June	Birth Year 20, 1	Montgar 91.8 gr	thplace (State or Foreign ountry)
	Maryland f show	tor	Usual Residence of 10a. State	10b. County Montge	omery		ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	i Direc	10e. Street and Nu 1001 Sp		reet, #424	1		10f. Zip		910				zen of What C	ountry?
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, If a Medical Examinar must be nuffled at	Completed by Funeral Director	11. Marital Status 1 Never Marital 3 Widowed	ried 2 Marrie 4 Divorced 15. Decedent's	If Yes, Give Year or Dat	es? X No		Was Deced If Yes, spec 1 ☐ Yes	2 X No	Specify:		cify Yes or Rican, etc.)		14. Race - Am Black, Whi Specify: B	te, etc. Lack
21215-0036	I within 72 jene. r than "nat	ompiete	(Spe	cify only highest	college (1-4	lor 5+)	(Give	kind of woi DO NOT us	rk doné d se retired	turina mos	t of worki	ng			Industry
Maryland 2	should be filed withir and Mental Hygiene. marked othar than matic event, Ira Ma	To Be C	17. Father's Name James B		ast)							(First, Midd	lle, Maiden		
Mary	nd 2 shoutd alth and Men 27 is marke r traumatic		19a. Informant's N					•					-	Town, State, MD 209	
Baltimore,				,	3 □Removal from St	ate (Place of Disponentery, cre	matory or o	ther plac		9 17-	ate -05		cation - City or	
Baltii	permit. Page Department o Important: If any injury or once.		21. Signature of F			en) 2	2. Name an	d Addres	s of Facilit	ty I	Bell F	unera	1 Home,	
3760,	Physician /Medical Examiner	licai Examiner	23a. Far . Enter thick, or her finds, or her finds, or her large or conditions and the condition of the cause. Enter Und Cause . Enter Und Cause (Disease of that initiated event resulting in death)	(Final on on on on on on on on on on on on on	Due to (o b. Due to (o	as a consec	quence of):	ter the mod	le of dying	g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	the attending phed for use as	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Tyes 2 9 Tunknown	months?		h 2 ∏ Feta ntattime of c	aldeath 3[∃Ectopic pr]Other (sp	,	-			2	3d. Date of de Month	olivery Day Year
	quires that the signed by all be detacted	b	7	ificant condition	ns contributing to dea	th but not res	sulting in the u	inderlying c	ause give	en in Part I					o the cause of death?
Records,	The law requir ate has been si page 2 should	Completed										24a. Wa au pe 1 ☐ Yes	topsy rformed?/	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	Physician: this certificaral director, I	o Be C	25. Was case refe examiner? 1 \(\text{Yes} \) 2 \(\text{L} \)		Hospital: 1 ☐ Ing	nationt 2] ER/Outpatie	nt 3 DC	Othe	200		(Check onl		□Other (Spe	acrific)
Division of	Jing After fune	Certification; To	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident		28a. Date of (Month, ation	Injury Day Year)	28b. Time o Injury	f 2	8c. Injury Work 1 🔲 `	100.0	No	28d. Describ	e how injury	occurred	
Divi	i i i i		3 ☐ Suicide 4 ☐ Homicide	determin	ned 28e. Place o building	, etc. (Special						City or 1	Town, State)		ural Route Number,
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical E	y Physicien: To the be exeminer: On the bas and manne	is of examina		vestigation	, in my op	oinion, dea			e, date and		e to the cause(s)
	S With	2	29b. Signature and	mue C	Gen Sort	t, m	,0	1)		9 number	6		09	/19/0	
K	(0)		30. Name and add		vno completed cause	UC, #	302,	Bet	hesc	la,	MI	20	814.		
	Sta Registi		31. Date filed (Mod SE	nth, Day, Year) P 1 9 20		gistrar's Signa	dure fra	de la							

State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Theodore Roosevelt Boud September 11 2005 0346 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Yrs Director 144-26-2249 70 1935 New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them than "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Itams 23a or 28a-f show traumatic svant, the Medical Examinar must be notified at 1 ☐ Yes ZXNo Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 Conway Road 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify þ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Bus Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Harris (Friend) 1115 Romancoke Road, Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 9-13-2005 Baltimore, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 10 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) ne 444 01 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed certificate To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 atient 2 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after deam.
To the Funeral Director: # investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of per who completed cause of death (Item/23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **SEP 1 4 2005** Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie U U 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Sherman McKinley Bittinger Sept. 18 2005 12:47p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hollow Rd. Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1ØM 2□ F Days Director June 25, 1926 Maryland 216-22-6957 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28e-f show other traumetic event, the Madical Examiner rust be notified at Maryland Baltimore Ellicott City 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Hollow Road 21043 USA Itams 23a Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. Yes 2 Yes, Give 1 Never Married 2 Married 2 No ŏ White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: Korean 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Catonsville Custodial Office Community College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) : 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Velma Wilt Frank Bittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 720 Hollow Road, Ellicott City, MD Kenneth M. Bittinger, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 to 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or = 5 14 ☐ Donation 5 ☐ Other (Specify) Grantsville Cem, Sept 21, 2005 Grantsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funefal Service Licenses Y amas 179 Miller St, PO Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-salure. List only one cause on each line. Approximate
Interval Between
Onset and Death
27years Immediate Cause (Final disease or condition resulting in death) of Diabetes Mellins Physician Complications /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Hospitel or Attending Phyaician: The law requires that the death certificate be executed Due to (or as a consequence of) physician street the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

Physician/Medical Examiner þ Be Completed 9

in the past 12 months? 1 ☐ Yes 2 ☐ No

1 🗌 Yes

1 Natural

2 Accident

4 Homicide

3 Suicide

esn for ed by the a detached f page 2 s Certification:

has certificate

this

After

death.

23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Magner of Death

Division of Vital Diractor: 24 hours a within 2 To tha To the

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

O4VA

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier seuro

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

3 Ectopic pregnancy

5 Other (specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

2 No

1 🗌 Yes

2 No

28d. Describe how injury occurred

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) EICHTL

4☐Pregnant at time of death

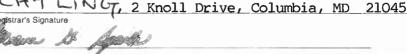
IDIDEMIA

1 Inpatient

28a. Date of Injury (Month, Day Year)

DR. DAVID 31. Date filed (Month, Day, Year) 32. Registrar's Signature

23



2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

			For	State of Marylar		artment	t of He	alth an	d Mental F	lygien	e	
	7. 8		1 State Registrar		Cei	rtificate	e of D	eath	la Birit		2005	
	Physici		Decedent's Name (First, Middle, La Franklin Orland						2. Date of Month Sept.		2005 Year	3. Time of Death 2:14 P M
4	/Medi Examir		4a. Facility Name (If not institution, given	ve street and number)		4b. City,	Town, or L	ocation of D			c. County of Death	
		esc 1	Calvert Memorial	Hospital	to a de Cada de La	Prin	ce Fr	ederi			Calvert (County
	Funeral Director			5ex 7. Age (In yrs. 1	Yrs.	Months Months		If Under 24 Hours A	Ain. (Month,	Day, Year		iplace (State or Foreign intry)
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo	1			Aug.	نا و ا		nington, DC
	Maryla f ahor	tor										10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28a	Funeral Director	MD Calvert 10e. Street and Number	County Ch	esapea	10f. Zip				10g. C	itizen of What Cou	
	ath wil	rai D	2802 Glasgow Way			-	732				J.S.A.	
	ter de itam	-une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces?	l.S. 13. \	Was Deced f Yes, spec	ent of Hisp ify Cuban,	anic Origin' Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri Black, White	ican Indian, , etc.
21215-0036	in 72 hours after death with the Maryland "natural", or itame 23a or 28a-f ahow kolcal Examinat must be notified at	by	3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	5	1□Yes 2	No No	Specify:			SpecifyWhit	e
15-0	"natu	Completed	15. Decedent's E (Specify only highest gr		16a. Deced	dent's Usua kind of wor	l Occupation	on ring most of	working	16b. h	Kind of Business/Ir	ndustry in Police
212	filed within Hygiene. Wher then "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Police						epartment	
nd		Be	17. Father's Name (First, Middle, Last		120220	<u> </u>		8. Mother's	Name (First, Mid	dle, Maide	n Sumame)	
Maryland		To	Franklin Orlande						Gerbens			
Z	s 1 and 2 should i Health and Mer itam 27 is marke other traumatic		19a. Informant's Name/Relationship		1:						or Town, State, Zi	
ore,	ss 1 and 2 of Health litem 27 i		Barabara A. Bowma 20a. Method of Disposition	20b. F	Place of Dispo	sition (Nam	of her place)	y, cni Sei	ot. Date 13.	20c. L	Docation - City or T	and 20732 own, State
Baltimore,	Page tment tent: if jury o		1 ☐ Burial 2 MCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr	(v) Le	e Crema	atory			2005	Cli	nton. Ma	rvland
Bal	permit. Pages. Department of It Importent: If Its any injury or of once.		21. Signature of Jane 11 2 rv Lice	13	22 Q	Name and	Address	of Facility∐.€	e Funer	al Ho	me Calve	rt, P.A. MD 20736
			23a. Part1. Enter the disease, or corr	nplications that caused the deat							owings,	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.								Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. ACUTE RE Due to (or as a conseq					7-0			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. MASTHE Due to (or as a conseq	uence of):	GKI	4015	>				
	cuted nd ransit	Examiner	that initiated events	C								
8760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):							· · · · · · · · · · · · · · · · · · ·
687	leath certificate t attending physic I for use as the b	edicai		d								
Box 6	h certi ending	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		\					23d. Date of delive	ery
O. B	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of d		Ectopic pre Other (spe				-	Month	Day Year
P.O.	that the od by detact		Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderiving ca	use given i	in Part I.	23e. Di	d tobacco	use contribute to t	he cause of death?
Division of Vital Records,	quires in sign uld be	ed by	CHRONIE OB:					15 EAS		Yes 2		pably 4 Unknown
eco	e law re has bee je 2 sho	Completed							24a. W	as an topsy	24b. Were auto	ppsy findings available
E	The ate	Соп							ре	rformed?	death?	mpletion of cause of 2□ No
<u> </u>	Attending Physicien: The r death. ector: After this certificate h. by the funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ER/Outpatien		Other		Death (Check onl			
υ of	ng Phys ter this neral dii	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury at Work?	4 🗀 NUI SIII	g Home 5 ☐ Re 28d. Describ		6 □Other (Specifing occurred	(y)
sior	tendir leath. tor: Af the fur	catic	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	n		М	1 Tes	s 2□No				
ΩĬ	I or At after c Direc	Certification:	4 Homicide determined		ome, farm, stre y)	eet, factory,	office		28f. Location City or	(Street ar Town, State	nd Number or Rura e)	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	nysician: To the best of my kno	wledge, death	occurred a	t the time,	date and pla	ace, and due to the	ne cause(s) and manner as s	tated.
	To the H within 24 To the Fu complete	Medical	one) 2 Medical Exar	niner: On the basis of examina and manner stated.	tion and/or inv	estigation, i	in my opini	ion, death or	ocurred at the tim	e, date an	d place, and due to	o the cause(s)
	To To	<	29b. Signature and fittle of certifier	hard.	110		License ni			1	te signed (Month,	
•			30. Name and address of person who	completed cause of death (Item			104	037		//	13/03	
0	20+1		Peter L. Wisniew	ski, M.D. 110	Hospi		oad,	Prince	Freder	ick,	Maryland	20678
	Sta Registr	te ar	31. Date filed (Month, Day Year) SEP 1	4 2005 Registra s Signa	ture &	Soci	K					

			For State Registrar	State of	Maryland		artment of H		and Men		iene 0	05	319	341
		П	Decedent's Name (First, Middle	le, Last)						Date of Death	1		3. Time o	f Death
	Physicia /Medic		Guido Gonza	alez Busta	mante				_	Month ptembe	r 17.	Year 2005	12:45	AM
7	Examin		4a. Facility Name (If not institution	n, give street and num	iber)		4b. City, Town, or	Location o			4c. County	y of Death		
			7921 Goodhurs				Gaithers		0411		Mont	gomer		
	Funeral		5. Social Security Number	6. Sex 1X M 2 ☐ F	7. Age (In yrs. Ia		If Under 1 Year Months Days	Hours	Min. /	Date of Birth Month, Day,	Year)	Cour	place (State ontry)	or Foreign
	Director		591-01-3725 Usual Residence of Decedent		88	3			Má	ar 15,	1917	Cuba		
	yland now		10a. State 10b. County	,	10c. City,	Town or Lo	cation					1	I 0d. Inside C	ity Limits
	Mar B-f st	tor	Maryland Montgo	omerv	Gait	hersb	urg						1 🗌 Yes	2 ₹ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?	
	death with the Maryland ims 23a or 28a-f show r.must.be rudifiad at		7921 Goodhurst	Drive			20882			U	SA			
	tems	Funerai	11. Marital Status	Armed For			Was Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Specify n, Puerto Rica	Yes or No- in, etc.)		ce - Americk, White,		
36	s afte	by Fi	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	9	İ	1 ☐ Yes 2 X No	Specify:			Specif	^{fy:} Whit	_	
8	be filed within 72 hours after death with the Marylar tal Hygtiene, od other then "naturel; or items 23a or 28a-f show od other then "naturel; or items 23a or 28a-f show event, the Medical Examination must be retified at			nt's Education	1105.	16a, Dece	dent's Usual Occupa	ation		1	l6b, Kind of B			
15	n "ne	Completed		st grade completed)	40r 5 v)	(Give	kind of work done of DO NOT use retired,	turina most	t of working		iob. Kind of E	, 451110534111	addity	
212	e filed within al Hygiene. other then "	mo	12	College (1	401 54)	Busin	ess Owner			SI	hippin	g Ind	ustry	
2	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (Fil	rst, Middle, M	faiden Sumar	me)		
Vai	should b and Ments s marked umetice	To E	Jacinto Gonzale	ez de Busta	amante			Candi	ida Luc	que Du	que			
Maryland 21215-0036		1 8	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rural Ro	ute Number,	City or Town	, State, Zip	Code)	
	os 1 and 2 of Health I item 27 I		Felicia E.G. Bu	istamante/	wife Bob Blo		Goodhurst	Driv	ve Gait					
Baltimore,	Pages 1 nent of H nnt: If ite ury or ot		20a. Method of Disposition 1 □ Burial 2X Cremation	3 Removal from S	State Cer	metery, crer	sition (Name of natory or other place	. -	Septeml	oer	20c. Location	- City or To	wn, State	
ţi	t. Pa rtmen rtent: njury		`4 □ Donation 5 □ Other (S	20, 200	05 (Odento:	n, Ma	ryland	i					
Bal	permit. Pages Department of Importent: If i eny injury or on		21. Signature of Funeral Service	Hold	MO1		Name and Address oing Home everly L.			Servi	ce P Clark	O. Bo svill	ĕ, ⁷ 84	21029
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca t only one cause on ea	aused the death. ach line.	Do not ent	er the mode of dying	g, such as	cardiac or res	spiratory arre	st,		Approximat Interval Bet	tween
	Frysician	d III	Immediate Cause (Final disease or condition	_a_ Ch	Nouse	4	mbert		len	Kerni	12	. 1	2 dea	
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	1, 1			*************				
			Sequentially list conditions, in any, leading to immediate	b. — Due to b	or as a conseque	ence of		_						10-
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	₹	or as a correcção	51100 01).		-						
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):	· · · · · · · · · · · · · · · · · · ·							
8760,	icate be ex physician s the buria	dicail		d.				-						
9	the death certificate be executed y the attending physician and iched for use as the burial-transi	ledi												
Вох	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		Ectopic pregnancy					ate of delive	-)
	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of dea		Other (specify)				Mo	onth	Day	Year
P.0	that the d ed by the detached	Phy	9 Unknown								1			
S,	se ug	by	Part II. Other significant conditi	ons contributing to de	ath but not resul	iting in the u	nderlying cause give	en in Part I.			acco use con s 2 ⊠No		ne cause of o	123
or o	w requir been si should	ompleted												
3ec	S S S	mpi								24a. Was an autopsy perform	24b.	Were auto prior to con death?	psy findings mpletion of c	available ause of
a	Th page	O										1 Yes	2□ No	
Vital Records,	Physicien: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			t all DOA Othe	20	of Death (Ch					
of		: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 1 1		R/Outpatier 28b. Time o	IL 3 DOA	4 🗀 IVU			nce 6 Oth		r)	
OU	ding h	tion	1 Natural 5 Pendi 2 Accident invest	ng (Monti	of Injury h, Day Year)	Injury	Work	<br Yes 2 □ I						
Division	of or Attending after death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At hon	ne, farm, str	eet, factory, office		28f.	Location (Str	eet and Numl	ber or Rura	il Route Nun	nber,
		Certification:	4 Homicide	buildir	ng, etc. (Specify)					City or Town,	. State)			
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the ba and mann	asis of examination	rledge, deatl on and/or in	n occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, and the occurred a	due to the ca t the time, da	use(s) and ma te and place,	anner as si and due to	ated. the cause(s	5)
	To the within 2 To the complet	Me	29b. Signature and title of certific	ər			29c. License	number		29	d. Date signe	ed (Month,	Day, Year)	
	0		A Tilan	21 (0)	MD		DSI	666	3	S	ndeus	n 10	1 200	5
1	2		30. Name and address of person	who completed caus	e of death (Item:	23а) (Туре,	Print)			1	1		1.00	
10	2 Sta	ite	31. Date filed (Month, Day, Year	Philip (Sistrar's Signatu		barke	806	52	Mel.	10 N cl	Kali	IM	9
	Registi		SEP 2	0 2005	leve ,	K A	bark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Baldwin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 329 Williams Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jul 31, 1955 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2**X**□F 50 212-84-5750 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21502 USA 329 Williams Street permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "neturet", or Items 23s any Injury or other treumatic event, tre Macical Examiner must any Injury or other treumatic event, tre Macical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify:white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheetz Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Leonard Howsare Susan Elizabeth (Steele) Howsare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Williams Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Prin husband James Baldwin 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Restlawn Memorial Gardens 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/27/2005 MD LaVale 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Na Scat petitis Putieiral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Park. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 \ No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Hesidence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

with the Maryland

Baltimore, Maryland 21215-0036

certificate be executed

Division of Vital Records, P.O. Box 68760,

Hospitel or Attending Physicien: 24 hours after death.

To the Hospitel of within 24 hours at To the Funerel D

funeral director,

After

Director:

burial-transit

use as the

Item 27 le marked other then "neturel", or Items 23a or 28e-f show other treumatic event, the Mactical Examiner must be notified at

State Registrar N Ranjithan M.D.

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person who a pulsed ause of death (Item 23a) (Type, Print) 517 Oldtown Road Cumberland MD 21502

		State Registrar	te of Maryland	/ Depa		ealth and	_	iene 2005	31943
		Decedent's Name (First, Middle, Last)			inoaic or E	Jeann	2. Date of Deat	og. 110.	3. Time of Death
Physic		James B. Coulter	r				Month	Day Year	
/Med		4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of De		er 9, 2005 4c. County of De	
Exami	ner	778 Eastern Point Rd.			Annapol:		401	Anne Ar	
Funeral		5. Social Security Number 6. Sex_	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 H			irthplace (State or Foreign Country)
Director		499-09-1212	□F 85	Yrs.	Months Days	Hours Mi	n. (Month, Day, 8-2-19)		clahoma
р.		Usual Residence of Decedent							
arylar show	_	10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Lîmits 1 ☐ Yes 2XXNo
88e-1	ctc	Maryland Anne Arunde	<u> </u>	Anna	polis				
with the	by Funeral Directo	10e. Street and Number	1		10f. Zip Code		1	0g. Citizen of What (Country?
s 23	erai	778 Eastern Point Ro	1 . Is Decedent Ever in U.S.	112.1	21401		(Secretary Secretary	USA 14. Race - An	a siena Indian
ter de	n.	Arg.	ned Forces? Yes 2 □ No	13. 1	Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- arto Rican, etc.)	Black, Wh	
hours at turel', or	by	14.34	es, Give ar or Dates: 1940-5	2	☐Yes 20XNo	Specify:		Specify: V	White
2 hour	Completed	15. Decedent's Education		6a. Decec	ent's Usual Occupa	ition		16b. Kind of Busines	s/Industry
thin 7	pje	(Specify only highest grade comp		life. (kind of work done of OO NOT use retired,)	rorking		
A de will will be a de will be	Son	5+	Д	atura	ary of I Resour	ces		State of	Maryland
y land	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	*	
Vid Men Men arke	5	Robert L. Coulter	1				ise Robins		
Mar d 2 sh th and th and traum traum		19a. Informant's Name/Relationship (Type, Pri					Rural Route Number,		
C, C		Norma B. Coulter/ Wif		778_E	lastern Po	oint Rd	. Annapol	Lis, MD 21 20c. Location · City of	401
or of the		1 ☐ Burial 2 X Cremation 3 ☐ Remova	I from State	etery, cren	natory`or other place	9)			
Dallimore, bermit. Pages 1 a Department of Hea mportant: If item ny injury or othe		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Kal		ematory	1		Edgewater	
Daillillore, Marylatin Z.1.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Eran and minist be indiffible at once.		21. Signature of Property and Service incertises		22	073 Solor	none To	George P. Land Kd. H	Kalas Fun	eral Home
		23a. Part1. Enter the disease, or complications	s that caused the death. I						Approximate
300		shock, or heart failure. List only one cause Immediate Cause (Final	se on each line.		nelauc		ar or roop natory are	,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Oue to (or as a consequen		readic	,,,,,			5 years
Examiner			oue to (or as a consequen	ce oi).					
-0 V	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):					
cuted od ransit	Examiner	triat initiated events							
e exe		resulting in death) Last	Due to (or as a consequen	ice of):					
certificate be executed inding physician and ise as the burial-transit	licai	d							
BOX 00 leath certificat attending phy for use as th	Physician/Med	IF FEMALE:							
death cer death cer e attendir ad for use	ian	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal de	ath 3	Ectopic pregnancy			23d. Date of d	elivery Day Year
the de	ysic		Pregnant at time of death Unknown	n 5L	Other (specify)				
wrequires that the death cer been signed by the attending should be detached for use		Part II. Other significant conditions contributing	ng to death but not resultin	ng in the ur	derlying cause give	in in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
utres utres r sign Id be	d by						1 □ Ye	s 2 ∑ no 3⊟F	Probably 4 Unknown
w requ	ompieted						24a. Was a		autopsy findings available
The law The law ate has b	m d						autops: perform	y prior to death?	completion of cause of
VICION: The sicion: The certificate rector, pag	C	25. Was case referred to medical				26 Place of D	1 ☐ Yes 2 eath (Check only only	No 1 □ Ye	s 2 No
Of VICA Physicien: This certific ral director,	0 B	examiner? 1 Tes 2 No Hospita	l: 1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3□ DOA Othe		Home 5 Reside		ecify)
ding Physicien: The land. After this certificate hat the director, page	ī.	27. Manner of Death 28a		b. Time of Injury	28c. Injury Work		28d. Describe ho		
Attending r death, ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Moral, Day , Oar)	injury		/es 2□No			
UNISION a) or Attendin a after death. I Director: After din by the fur	Certification;	3 Suicide 6 Could not be determined 28e	Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Cer						1		
To the Hospitel of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier 1 Certifying Physician: 2 Medical Examiner: On	n the basis of examination	idge, death and/or inv	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ce, and due to the ca curred at the time, da	tuse(s) and manner a ate and place, and du	as stated. ue to the cause(s)
the the the the the	Med		d manner stated.		29c. License	number	20	9d. Date signed (Mor	oth Nav Year)
To Viet	-	S. Below	Wywo		D I	9839	3 "	9/17/7	200
		20 Name and oddings of any	ad course of death (the on	(a) (T.	Orint)	, - <i>D</i> (-111010	
		30. Name and address of person who complete 31. Date filed (Month Day Year)	ONICH 9	OO	Bestaco	ke Rd.	Annap	olis, md	. 21401
S	tate	31. Date filed (Month, Day, Year)	32. Projetrar's Signature	9	7	, (7		,	
Regis		SEP 1 4 2005	Down B	3 1	and I				

		•	For State Registrar	State of Marylan		irtment of H tificate of I			giene Reg. 2. (005	319	44
		#	1. Decedent's Name (First, Middle, La	ast)				2. Date of De			3. Time o	f Death
	Physicia /Medic		Dorothy May Cook					Septeml		Year 2005	2:05	\mathbf{P}^{M}
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death	1	4c. C	ounty of Death)	
			Northampton Manor			Frederic		1 21 - 12		derick		
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age (In yrs. 1 ☐ M 2X F	• • •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	iplace (State of	or Foreign
	Director		219-01-6127 Usual Residence of Decedent	00	,			Jan. 19	9, 191	19 Mary	Land	
	yland yland		10a. State 10b. County	10c. City	, Town or Lo	cation					10d, Inside C	ity Limits
	a-fs	ctor	Maryland Frederic	k Frede	erick						1 X Yes	2 🗆 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	intry?	
	ath w	Funerai Directo	550 Heatheridge D			21702			USA			
	er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🕅 No	S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Si ın, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	. Race - Amer Black, White		,
36	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Items 23a or 28a-f show the than "natural" or Items and be notified at	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes 2X No	Specify:		S	pecify:	ite	
5-0036	2 hot		15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	ation		16b. Kind	of Business/		
2	b. "n	Completed	(Specify only highest gas Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	kind of work done of OO NOT use retired	during most of wor f)	King				
2121	ed wi	Sol	12		dairy	farm				culture	1	
aryland	0 2 2 2	Be	17. Father's Name (First, Middle, Las				18. Mother's Nan			umame)		
Z	1 Men narke	T _o	John William Ruth		401 44 11		Myrtle L					
Z Z	12 sh hand 7 lan traun		19a, Informant's Name/Relationship			g Address (Street			, ,		,	1701
	es 1 and 2 should b of Health and Ment f Item 27 la markec r other traumatic e		Ellan Bausum, gra	20b. P	lace of Dispo	St. Lawre stition (Name of	1	Date		Mary I ntion - City or 1		1701
<u>o</u>	Pages nent of int: If It ury or o		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	-	natory or other place et Cemete		/2005	Frede	erick,	Marvla	nd
altimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Lice			. Name and Addre						
m	Per Imp		Kuan M. 3	Derg MOC	999 10	06 East C	hurch St	reet, Fi	rederi	ick, Ma	ryland	2170
П			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplication that caused the death y one cause on each line.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximation	tween
jurge	Physician		Immediate Cause (Final disease or condition	a Pneumonia							Onset and 4-5 Day	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
		10	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ieuce of).							
	uted Insit	min.	Cause (Disease or injury									
o T	execting and ital-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):							
68760,	ficate be executed physician and is the burial-transit	edicai		d								
		Med	IF FEMALE:						1			
Вох	leath certifi attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	death 3	Ectopic pregnancy			23	d. Date of deli-		Year
0.	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant at time of di 9□ Unknown	∍ath 5∟	Other (specify)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	res that the de igned by the a be detached t		Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of o	death?
ds	uires n sign lid be	d by	Hypertension					t 🗆 :	Yes 2 X	No 3□Pro	bably 4 🗆	Unknown
00	w requir s been si should	iete				-		24a. Was	an	24b. Were aut	opsv findinas	available
Be	The lavate has page 2	Completed						auto perfo	psy ormed? 2X No	prior to c death? 1 ☐ Yes	ompletion of a	ause of
ita		0	25. Was case referred to medical				26. Place of Dea			1 1 1 1 1 1 1 1	2010	
<u>></u>	hysician: this certifica al director, p	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA Oth	er: 4X Nursing H	ome 5 Resi	dence 6 [Other (Spec	ify)	
o u	Attending Physician: r death. ector: After this certification in the funeral director.	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury o	occurred		
Sio	tendi death tor: /	icat	2 Accident investigati 3 Suicide 6 Could not	he	4		Yes 2 □No	204 Landing (Otenna to and a		/ / / / / / / /	
Division of Vital Records,	f or Atten after deat Director: I in by the	Certification:	4 Homicide determine			eet, factory, office		28f. Location (. City or To	wn, State)	vumber or Hul	rai Houte Num	iber,
_	apltal		29a. Certifier 1 X Certifying F	hysician: To the best of my kno	wledge, death	occurred at the time	ne, date and place	, and due to the	cause(s) ar	nd manner as	stated.	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai		miner: On the basis of examina and manner stated.								;)
	To the To the Comp	Ž	29b. Signature and title of cartiner			29c. Licens			29d. Date :	signed (Month	. Day, Year)	
		10) Apri				1643		9-	27-0	5	
	3	100	30. Name and address person wh	1 - 1	1 23a) (Type,	HILLEH	Shah, MI	0	0 -0	177-17		
	Sta	tė.	31. Date filed (Month, Day, Year)	A. Registrar's Signa	ture A		denc	k m	$1) \propto$	1702		
	Regist		OCT 0 3 20	05 Maries St	STORE							

05-6540 B.K.S

BEVE	RLY CLEN	ME	R see	State of	Maryla	nd / De	oartmei	nt of H	lealth	and M	ental Hy		•	le.	
			1 - State Uppend Item 1. Decedent's Name (First, Middle, La		8a-f	per me	effff&a	100/1	bean	tas	2. Date of De	Reg. No	AAA	_	OTide of Odeth
	Physicia		Beverly A. Cler								Month SEPT.	Da		5	STinle Opening
	/Medic Examin		4a. Facility Name (If not institution, giv		nber)		4b. City	, Town, o	r Location	of Death	DIE I.		County of	Death	1/10 1
	Examin	Ŭ.	1603 PEACOCK LAN	Е				SILV	ER S	PRING		1	MONTG	OMET	RY
325	Funeral Director		228-70-5579	ex □M 2 □X F	7. Age (In yn	rs. last birthda Yrs.	y) If Under Months	r 1 Year Days	If Unde Hours		8. Date of Bi (Month, Da April	ay, Year)			place (State or Foreign ntry) .rginia
	and	}	Usual Residence of Decedent 10a, State 10b, County		10c. (City, Town or	Location							1	0d. Inside City Limits
	Maryl f ehc	ō	Maryland Montgor	nerv		Silver	Sprir	α							1 ☐ Yes 2 ☐ No
	1 the	Director	10e. Street and Number					p Code	-	_		10g. Cit	lizen of Wh	at Cour	ntry?
	h with	O	1603 Peacock Lar	ne			2	0904	ļ.					US	A
	eme ?	ner	11. Marital Status	12. Was Dece Armed For	dent Ever in	U.S. 1:	B. Was Dece	dent of H	lispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race -	Americ White,	
36	or it	by Funeral	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes If Yes, Give	2 (X No		1 🗆 Yes		Specify		110011, 510.7		Specify:		
ő	72 hours after death with the Maryland tratural, or iteme 23e or 28e-f ehow digal Examinat relative indilited at	d b	3 Widowed 4 Divorced	Year or Da	ites:	150 P-						1 101 1			
1 5-	in 72	Completed	15. Decedent's E (Specify only highest gra	de completed)		(Gi	edent's Usi ve kind of w DO NOT	iai Occup ork done ise retired	xation during mo d)	st of worki	ng	16b. K	and of Busi	ness/in	dustry
212	with iene.	E O	Elementary/Secondary (0-12)	College (1-	-4or 5+)		ecreta		,				T.	aw	
Þ	e filed Il Hyg othe	BeC	17. Father's Name (First, Middle, Last,)					18. Moth	her's Name	(First, Middle	e, Maiden			
10	uld b Menta rrked ritic e	To E	James B. Eades						Sa	ra Po	rterfi	eld			
Baltimore, Maryland 21215-0036	and h		19a. Informant's Name/Relationship (Type, Print)		19b. Ma	iling Addres	s (Street	and Numi	ber or Rura	Route Numb	ber, City o	or Town, St	ate, Zip	Code)
≥	and sealth m 27		Sara P. Eades/ N	Mother	-	160	Peac	ock	Lane	, Sil	ver Sp	ring	. Mar	ylar	nd 20904
ore	Ses 1		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from S	1	. Place of Dis cemetery, c	position (Na rematory or	me of other plac	ce)	Sept	28,	20c. L	ocation - Ci	ty or To	wn, State
턡	tmen tant:		4 Donation 5 Other (Special		Me	etropoli					005				Virginia
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow eny injuryen other traumatic event, the Medical Examinar trausities are pose.		21. Signature of Funeral Service Lice	nsee On]	22 Name a Franci 500 Un	nd Addre s Ver	sity	lins Blvd	Funeral	l Hor Silve	me Ind	c ring	g, MD 2090]
8760,	Physician /Medical Examiner physician and physician and physician and the pruial-transit	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Narcot Due to (c	tic In or as a cons	equence of):		de di dyii	ig, such a	s cardiac c	respiratory a	arrest,			Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68	Physician: The law requires thet the death certificate this certificate has been signed by the attending physral director, pege 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 MUnknown		irth 2 ☐ Fe ant at time of	etal death	3 □Ectopic p 5 □ Other (s		′				23d. Date of Month		ery Day Year
rds, F	w requires thet s been signed b s should be dete		Part It, Other significant conditions of	contributing to de	ath but not r	resulting in the	underlying	cause giv	ren in Part	11.		tobacco (ute to th	ne cause of death?
000	s bee	olete									24a. Was	s an	24b. We	re auto	psy findings available
E Re	The lav	Completed									auto perfe 1 X Yes	opsy ormed? 2 \(\) No	dea	th?	mpletion of cause of 2 No
Vita	iclan: Th certificete rector, peg	Be	25. Was case referred to medical examiner?	Hospital:				1 04		ce of Death	(Check only				
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director,	tlon: To	1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Found	of Injury h, Day Year)	28b. Time	of	28c. Injur Wor	4 🗆 🗅	- 1	me 5 Res 28d. Describe		6 Other		unk
Divisi	tal or Attending s after death. el Director: After ed in by the funer	Certification:	3 ☐ Suicide 6 Could not be determined	28e. Place buildir	of Injury - At	4:00 t home, farm, ecify) esidence	street, facto				28f. Location (City or To Silver				acock Lane
	Hospital 24 hours a Funarei I	Medical	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the miner: On the ba and mann	isis of exami	knowledge, de ination and/or	ath occurred investigation	at the tire, in my o	me, date a pinion, de	and place.	and due to the	cause(s) and mann	er as s	tated. o the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifier				29		e number			29d. Da	ite signed (Month,	Day, Year)
	F > F 0		I him his.	mid				0.0	C.M.E	1		SE	PT.	26,	2005
			30. Name and address of person who		e of death (t	tem 23a) (Typ 11 PEN	e, Print) N STRI	EET,	BALT	IMORE	, MARYL	AND	21201		
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. R										<u>. </u>	
	riegisti	ui.	OLF NO	2000	Will start of	-	-								

DHMH 17 Rev 1/2001

			For	State of Ma			artmen	t of H			•	giene n n	5	31946
		_1	State Registrar			Cer	tificate	e of E	Death			leg. No.	U	
П	Physicia		Decedent's Name (First, Middle, Last)					_			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	Eleanor 4a. Facility Name (If not institution, give st	M .		Cal	dwel		Location o		Septemb	er 10,	2005 of Death	2:30 a "
	Examin	er '	129 Patuxent Mobil		C			hian				Anne		del
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. I	last birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day			ace (State or Foreign
	Director		5/9-18-5433	M 2]X] F	84	Yrs.					June 9		New]	
	and w	- H	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10	Od. Inside City Limits
	Mary -f sho	to	MD Anne Arur	ndel			Lot	hian	1					1 ☐ Yes 2 X No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of W	hat Coun	try?
	23e c	la l	129 Patuxent Mobil					207				USA		
	er des Items	Funeral	TT. Maria States	2. Was Decedent Armed Forces? 1 ☐ Yes 2 📉 N		S. 13.	Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Ori n, Mexican	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	Black	- America k, White, e	
36	Irs aft	by	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	••		1 🗌 Yes	2 ⊠ No	Specify:			Specify	whi	te
Š	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation		16a. Dece	dent's Usua kind of wo	al Occupa	ation Jurina mosi	t of workin	ia .	16b. Kind of Bu	siness/Ind	lustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT us	se retired,)			fodoro	. 7 ~ ~ ~	rammant
2	be filed within 72 hours after death with the Maryland and Hygiene. All Hygiene dictor them "naturel", or items 23e or 28e-f show do ther then "naturel", or items and the hydical Exacritrer and be notified all event, the Madical Exacritrer.		12 17. Father's Name (First, Middle, Last)			sec	retar	У	18. Mothe	er's Name	(First, Middle,	Maiden Sumam		vernment
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28a-f show Importent: If item 27 is marked other then "naturel; or Item 32 is a marked other then "naturel; or Item 30 ones." In Madical Examination and the malified all sones.	To Be	Frank	Worth					Vio	let		Couch		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rurai	Route Numbe	er, City or Town,	State, Zip	Code)
Σ,	s 1 and 2. of Health alitem 27 is	-	E. Jean Haithcock	, daughte							tates,	Lothian		
lore	ges 1 it of H if itel		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	emoval from State		lace of Dispo emetery, crei			_ ' .				,	
Ħ	artmer artmer ortent njury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	9 -	Ar.	lingto	n Nat 2. Name an				_2005	Arling	ton,	VA
Ba	permi Depa Impo any ir		1) Olian Z.	Cro		R	ausch	Fun	eral	Home	, P.A.	, Owings	, MD	20736
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused e cause on each li	the deat	h. Do not en	ter the mod	le of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
4	Physician	11. 1	Immediate Cause (Final disease or condition	Hepat	1/51-	Adend	Carc	רט אני	man	rith	Meta	ary /Rib		3 months
B	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):					54.04.000			
		e e	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):				_				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
760,	be executed iician and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):								
6876	5 8	dical	d											
Вох 6	The law requires that the death certificate to has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome			7					23d. Dat	e of delive	ery
	death e atte	icial	in the past 12 months? 1 □ Yes 2 ØNo	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			□Ectopic pi □ Other (sp					Mor	nth	Day Year
P.0	that the de led by the a detached i	Phys	9 Unknowń			and the second second			an in Dayl		23a Did to	phaces use contr	ribute to th	ne cause of death?
	ires th signed	þ	Part II. Other significant conditions con	of Moute	e tem	uiting in the t	maenying o	- Cir	Milli		1 🗆 1			ably 4 □Unknown
ÿÖ	w require been si should b	eted	Prior History Right Chronic Atrial F	brillation	n) 45	Diabe	Local	monto	4. 7.	24a. Was	an 24b. V	Vere auto	psy findings available
Vital Records,	The lav	Completed		rdiovasci				1407	1611/4	104 1	perfo	rmed?	rior to cor leath?	npletion of cause of
tal		0	25. Was case referred to medical	THICOME	MW).	212450			26. Place	e of Death	(Check only o			22.10
	di Si	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 🗌 Inpati	ent 2□	ER/Outpatie						dence 6 Oth		y)
n of	fter ne		27. Manner of Death 1 № Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time o Injury	of A	28c. Injun Worl	yat k? Yes 2□	_	28d. Describe h	now injury occurr	ed	
Division	death.	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	iury - At h	ome, farm, st			165 2			Street and Numb	er or Rura	I Route Number,
Div	all or A	Certification:	4 ☐ Homicide determined	building, e	tc. (Speci	fy)					City or Tov	vn, State)		
	lospita hours unere		29a. Certifier 1 Certifying Phys	sicien: To the best	of my kno	owledge, dea ation and/or in	th occurred	at the tin	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and ma date and place, a	nner as st	ated. the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	one) 29b. Signature and title of certifier	and manner st	tated.				e number			29d. Date signed		
	Z × Z		General P.	Steme	N	1.0		D	172	45		9/13/	05	
•			30. Name and address of person who co	mpleted cause of	death (Ite	m 23a) (Type								
	12		Gerald P. Sterner				ındel	Med	ical	Cente	er, Owi	ngs, MD	207	36
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 3 2005	32. Regist	rars sign	ande								
	1.09100			E Salli										

			1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	artme <i>tifica</i>	nt of H te of L	ealth a Death	and M	ental Hy	/giene	200	5	31947
स्त <u>्र</u>	Physici	an an	1. Decedent's Name (First, Middle, La	st)							2. Date of D	eath Da	ıv	Year	3. Time of Death
(/Medi			ok							09	13	<u> </u>	05	12:02 P M
	Examir	er	4a. Facility Name (If not institution, giv						Location o			40	. County		
			Holy Cross Hosp 5. Social Security Number 6.5		e (In yrs. la	est hirthdayl		ilver	Spri	ng	8. Date of B	idh.	Mont		
	Funeral Director			I M 21€7 F	55	Yrs.	Months		Hours	Min.	(Month, D	ау, Year, .4 50		Cou	place (State or Foreign intry) 1. D.C.
	/fand		10a. State 10b. County		10c. City,	Town or Lo	cation								10d. Inside City Limits
	Mary 1-f eh	tor	D.C.		Wa	shing	ton								X∏Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Z	p Code				10g. Ci	tizen of W	/hat Cou	intry?
	23a (2920 8th. Stree	t N.E.				20017					USA		
Maryland 21215-0036	d within 72 hours after deeth with the Maryland jiene. r then "netural", or iteme 23a or 28a-f ehow tre Mexical Examinar must be inclified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ∰Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 3 If Yes, Give Year or Dates:				edent of Hi ecify Cuba 2 X No	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or N Rican, etc.)	0-		k, White	
5-0	72 h	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	lent's Us	al Occupa	ation furing most	of workii	na	16b. K	(ind of Bu	siness/Ir	ndustry
21	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)				luring most)		.3	77	a		
12	filed within Hygiene. other then		12th. 17. Father's Name (First, Middle, Last	1		Mai	Inter	ance	10 Motho	r's Nome	/Final Baindall				Office
and	ರ ಕ್ರಾ	Be		_							(First, Middle	a, Maider	Sumam	9)	
7	should be nd Mental marked o urnatic eve	은	Thomas Purcel			19b. Mailin	a Addres	s (Street a		ie B	rown Route Numb	ner City	or Town	State Zi	n Codel
	~ a = =		Elizabeth Redmon	**											MD. 20744
altimore,			20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Specif		Cer	nce of Dispos metery, crem	sition (Na natory or	me of other place	9)	D	ate	20c. L	ocation -	City or T	own, State
ıltir			21. Signature of Funeral Service Lices		Gle	nwood	Ceme Name a	tery	s of Facility	()9-2	0 - 05 sha11'.	Was.	hingt	on,	D.C.
B	permit. Departr Imports eny inje		1 DR m	22.16	.00						Washin				
	Physician		23a. Part1. Enter the disease, or com shock, beart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin Septic	10.	Do not ente							•		Approximate Interval Between Onset and Death 6 days
	/Medical Examiner		resulting in death)	Due to (or as		ence of):									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Periton		ence of):								4	6 days
8760,	cate be executed obysicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):			,						
9		/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	cv							22d Date	- 6 da (i)	
P.O. Box	y the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	death 3 🗌	Ectopic p Other (s	regnancy pecify)					23d. Date Mon		Day Year
	es that igned to be det	by P	Part II. Other significant conditions of	ontributing to death b	ut not result	ting in the un	derlying	cause give	n in Part I.		23e. Did	obacco i	use contri	bute to t	he cause of death?
rd	w require been sig should b	ed k	Dementia, Depres	ssion, PAr	kinso	n Dise	ase,				10	Yes 2	□No	3 Prob	oably 4X Unknown
Division of Vital Records,	e las has je 2	Completed	Seizure Disorder	2							24a. Was auto perfo		DI	nor to co	opsy findings available impletion of cause of
ta	ician: Th certificate rector, pag	Φ	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only		11	⊔ Yes	2□ No
>	N S F	To B	examiner? 1 🗌 Yes 2 📆 No	Hospital: 1 ⊠ Inpatie	nt 2 E	R/Outpatient	3 🗆 D	Othe	~		ie 5 ☐ Resi		6 □Othe	r (Specil	(v)
o uo	Attending Ph r death. ector: After th by the funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	Y Year) 2	28b. Time of Injury	М	28c. Injury Work 1 🔲 Y		2	8d. Describe				71
Divis	i the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	ne, farm, stre	et, factor	y, office		2	8f. Location (City or To	Street an wn, State	nd Numbe	r or Rura	al Route Number,
	n 24 hours a n 24 hours a ne Funerel D	edical	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 ★ Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examinatio	ledge, death on and/or inv	occurre	at the tim	e, date and inion, deat	place, a h occurre	nd due to the d at the time,	cause(s) date and	and man d place, ar	ner as s	tated. o the cause(s)
	To the within 2 To the complet	M	29b. Signature and the of certifier	Λ.	1		29	c. License	number				-		Day, Year)
			> Struck	rollo o	42W	in.M.	D	Do	057	763	0	SE	PT.	14	2005
n	(1)		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type, F	Print)								
	U		Anuradha Axur		301	Georgi	a Av	e. Si	lver	Snri	ng, ME		1000		
	Sta Registr		31. Date filed (Month, Day, Year) CFD 9 n 900		ır's Signatu	Pros			_,	PLLI	69 ILL	. 20	704		

			For State of Maryland / State Registrar	Department of H		ental Hygier	11115	31948
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		Joann P. Chaffey			Month 09-16-200	Day Year 05	5:03 PM M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	Location of Death		4c. County of Deat	
			31206 Nassawango Church Road	Salis			Wicomi	.co
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 7. Age (In yrs. last to 215-26-0557 67	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Oate of Birth (Month, Day, Yes 05-08-19	9. Birth Co 38 Mary	nplace (State or Foreign untry) 'land
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
	anyla shov	2						1 Yes 2 No
	Ba-f	Director	Md. Wicomico Sal	isbury 10f. Zip Code		100	Citizen of What Co	7.
	a or i	ក់	31206 Nassawango Church Road	21804		109.	U.S.	unity !
	eath	erai	11. Marital Status 12. Was Decedent Ever in U.S.		ispanic Origin? (Spe	city Yes or No-	14. Race - Ame	rican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Eracifical most be redilised at ODGe.	by Funerai	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	in, Mexican, Puerto f Specify:	Rican, etc.)	Black, White	e, etc.
ŏ	2 hou	ted		a. Decedent's Usual Occup	ation	16b.	Kind of Business/	Industry
215	hin 7	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of workir d)			
2	ar th	Completed	12 2	Activities D	irector	Nı	ursing Ho	me
Maryland 21215-0036	ild be file lental Hy kad oth ic evant	To Be (17. Father's Name (First, Middle, Last) Frank Patchett		18. Mother's Name Linda	(First, Middle, Maid	len Sumame)	
ary	shou ind M mar umat	-	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street	and Number or Rura	Route Number, Cit	y or Town, State, Z	(ip Code)
ž	alth a salth a 27 is		Samuel R. Chaffey, Jr. Husband	31206 Nassawa	ngo Churc	h Rd., Sa	lisbury.	Md. 21804
altimore,	of He of He Item		20a Method of Disposition 20b. Place	of Disposition (Name of tery, crematory or other place	! D	ate 20c.	Location - City or	Town, State
Ĕ	Page nent ant: If		4 Donation 5 Other (Specify) Wicon	nico Memorial	Pk. 09-2	0 - 05 Sa.	lisbury,	Md.
Balt	permit. Departr Importa		21. Lignature of Funeral Service Ucensee M00295	22. Name and Address 11673 Some		inman Fund Princess		
			23al Part 1. Enter the disease, or complications that caused the death. D. / shock, or heart failure. List only one cause on each line.	o not enter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician			CAWEER				Onset and Death
ı	/Medical		Infimediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of the con	e of):				
L	Examiner	L	Sequentially list conditions b. b. 1 & n ex					
	be sit	ine	if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	e ot):				
_	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence)	e of):				
8760,	be ea sician buria	<u>a</u>		,				
687	ficate phys	edicai	0.					
Box	eath certific attending p i for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	4.55			23d. Date of deli	very
ă	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown				Month	Day Year
P.O.	at the de by the a tached	hys	9 ☐ Unknown			1		
S,	res tha iigned be del	by F	Part II. Other significant conditions contributing to death but not resulting	; in the underlying cause giv	en in Part I.	10		the cause of death?
ord	v requir been si should	ted				1 Tes	2 No 3 Pr	obably 4 Unknown
Vital Records,	law las b	Completed				24a. Was an autopsy	prior to d	topsy findings available ompletion of cause of
E E	sician: The lar certificate has rector, page 2	S				performed 1 ☐ Yes 2 €	death? No 1 ☐ Yes	2600
VII.	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:	Outpostings 3D DOA Oth	26. Place of Death			
	Phys this ral dii	. To	1 Tes 2 Tho	Outpatient 3 DOA 28c. Injury	4 Nursing Hon	ne 5 Residence 8d. Describe how in		ufy)
no	ding h. After fune	tion	1 Matural 5 Pending (Month, Day Year)	Injury Wor	k? Yes 2 □ No		10.7 00001100	
Division of	r Attanding F er death. ractor: After by the funera	fica	3 Suicide 6 Could not be			8f. Location (Street		ral Route Number,
<u> </u>	after I Dira	Certification;	4 Homicide determined building, etc. (Specify)			City or Town, Sta	ate)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: Atter this certifics completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the tin and/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause od at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	omple	Me	29b. Signature and title of certifier	29c. Licens		29d. [Date signed (Month	
}	- > F U		Van W. Bellis in	n D2	8587		9/19/05	
			30. Name and address of person who completed cause of death (Item 23a Ei) Will It. 13ELLIS My, 32071 13			ine no	21804	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	4 / .			-	
	Regist		31. Date filed (Month, Day, Year) SEP 2 1 2005 32. Ref Strar's Signature	F Aparle				

Box 68760,
o
<u>Ч</u>
Records,
Vital
of
Division

			riease	State of Ma					-		egible.		
			1 - For State Registrar	Otate or Ivia	•	•	e of Death				005	3194	Q
			Decedent's Name (First, Middle, Las	st)					Date of Death	h		3. Time of De	ath
	Physici /Medic		Richard			allo	way		Month 9	Day	2005	2031	М
>	Examir		4a. Fecility Name (If not institution, give	street and number)	0.4	4b. City,	Town, or Location	of Death		4c. Co	unty of Death		
			Peninsula Rajo	nal Medi	(Den	er S	alism	M				nico	
	uneral		5. Social Security Number Q. S.	M	(In yrs. last birt	nday) If Under	1 Year If Unde Days Hours		Date of Birth (Month, Day,	Year)	9. Birthp Coun	ace (State or Fi	oreign
	irector		Usual Residence of Decedent		7	113.		1 18	- 1-4	8	Maryl	and	
yland	at		10a. State 10b. County		10c. City, Town	or Location					1	Od. Inside City l	Limits
э Маг	a-f s	ctor	MD Somerset		Dames	Quarter						1 Yes 2	□ No
ith th	or 28 29 no	Director	10e. Street and Number			10f. Zij			10	•	n of What Coun	try?	
ath w	s 23a nust	ra	11048 Messick Ro			10.111.5	21821				USA	1	
ter de	ltem iner r	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 AYes 2 □ No		if Yes, spe	dent of Hispanic O city Cuban, Mexica	an, Puerto Ric	ean, etc.)	14.	Race - Americ 8lack, White,		
21215-0036 d within 72 hours af	el', or	<u>م</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates: V		1 🗆 Yes	200 No Specify	y:		Sp	wecity: Whit	e	
:1 215-0036 within 72 hours after death with the Maryland	"neturel", or Items 23a or 28a-f show Lical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation		Decedent's Usu	al Occupation	est of working		16b. Kind	of Business/Inc	lustry	
igh in	M. H.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		ork done during mo se retired)						
filled v	ther t		12 17. Father's Name (First, Middle, Last)	none		Electr		her's Name /F	First, Middle, N		trical		
Maryland of 2 should be file	sed of	o Be	Elwood Calloway					n Nels		naicen Su	mame)		
should	mari	2	19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing Address	(Street and Numb			City or T	own, State, Zip	Code)	
Ind 2	27 is 27 is or treu		Alice E. Callowa	v/Wife	1 1	048 Mes	sick Roa	d Dame	oc 01121	rtor	MD 218	221	
es ta	r othe		20a. Method of Disposition	-	20b. Place of cemeter	Disposition (Na y, crematory or	me of other place)	Date	θ (1	20c. Loca	tion - City or To	wn, State	
Page Fage	ant: fi		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify				yterian	09/11/	2005 I	Princ	ess Ann	ae, MD	
Saltimore,	Department on maint and wenter Arygenter important: If item 27 is marked other then "neturenty injury or other treumatic event, I'm Madical once.		21 Signature of Funeran Service Licen	see*		22 Name a Hinman	nd Address of Faci Funeral	Home					
ط م	2 = 9 d	1	AMOS YKN	Kew A M	00295	11673	Somerset	Ave.	Prince	ess A	nne, M	21853	
			3a. Part1. Enter the disease, or composhock, or heart failure. List only	one cause on each line	ne death. Dor	lot enter the mod	se of dying, such a	is cardiac or r	espiratory arre	est,	6	Approximate Interval Betwee Onset and Dea	en ath
	/sician ledical		Immediate Cause (Final disease or condition resulting in death)	a ortes	1034		card	is var	rela	- de	Jane		
	aminer			Due to (or as a	consequence of	of):							
	d	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence o	of):							
cuted	nd ransit	Examiner	that initiated events	C.									
5U, be executed	hysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):							
9	physic the b	dical	•	d									
. BOX 68/ death certificate	ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of	foregnancy					224	Data of dollars		
eath c	atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic p 5 □ Other (s				230	d. Date of delive Month	Day Yea	ar
j 🖁	y the ached	nysl	1 Yes 2 No 9 Unknown	9□ Unknown									
S, F	ned be det	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying	cause given in Part	t I.	23e. Did tob	oacco use	contribute to the	e cause of dea	th?
COLOS w require	en sig ould b								1 □ Ye	es 2 🗆 l	No 3□ Prob	ably 4 Dunk	cnown
a v	as be 2 sho	plet							24a. Was ar	n a	24b. Were auto	psy findings ava	allable se of
E e	page	Completed							perform	ned?	death? 1 ☐ Yes	2 No	
VITAI	ector	Be	25. Was case referred to medical examiner?	Hospital:			26. Plac	ce of Death (Check only on	θ)			
Phys	r this	-: To	1 Yes 2 No 27. Manner of Death	1 Inpatien	2 E R/Ou		DA _ 4U N		5 Reside		Other (Specif	y)	
VISION Attending	: Afte	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Ir	njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐			,,			
VISION Attending	ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injur	y - At home, fai	rm, street, factor	y, office	281	f. Location (St. City or Town		Number or Rura	l Route Numbe	r.
	el Dir	Certification:	4 - Notticide	building, etc.	(Зресну)				City of Town	i, Siale)			
lospi A bour	Traffice Treason Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of inner: On the basis of e	my knowledge	, death occurred	at the time, date a	and place, and eath occurred	d due to the ca	ause(s) ar	nd manner as s lace, and due to	ated. the cause(s)	
the P	mplet	Med	one) 29b. Signature and title of certifier /	and manner state	ed.		c. License number				signed (Month,		
P 3	5 8		290. Signature and title of destine	Danna	N	12	7 1 3	2/9	7	9.	17-0	5	
			30. Name and address of person who o	copolated cause of de-	ath (Item 23a) /	Type Print)	DU	/		1	100		
			15 1 10	ran 304	34 m+	Horror	D23 Rd, Pri	rcess	Anne	MI	2180	53	
ð.	Sta	150	31. Date filed (Month, Day, Year)	32. Registrar	's Signature					•			•
	Registr	ar	SEP 14	2005	m &	Local							
DHMH 1	7 Rev 1/20	001		_		-							

		-	For State Registrar	State	of Maryland		artment of I tificate of			F	leg. Z. UU	5	319	50
	Physici		1. Decedent's Name (First, Mid	ddle, Last)						Date of Dea Month	Day	Year	3. Time of	
	/Medic				Cericole		45 City Town			Septemb	er 25 20		1515	РМ
	Examin	er	4a. Facility Name (If not institut		umber)		4b. City, Town, Elkton		of Death		Ceci			
	Francisco 1		92 Long Drive 5. Social Security Number	e 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birtl			lace (State	or Foreign
	Funeral Director		143-01-0750	1 X M 2□ F	90	Yrs.	Months Days	Hours	Min.	8. Date of Birtl (Month, Day AUG 27	1915	New	lace (State of try) York	
	p >		Usual Residence of Decedent 10a. State 10b. Cour		10c City	y. Town or Lo	cation					1	0d. Inside C	ity Limits
	ehov	ō				1kton								2 X No
	28e-1	Director	Maryland Ce	cil		IKCOII	10f. Zip Code				10g. Citizen of W	hat Cour	ntry?	
	ath with the Marylar 23a or 28e-f ehow	DI	92 Long Driv	e			21921				Unite	d St	ates	
	deati	Funerai	11. Marital Status	12. Was De	cedent Ever in U.	S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori ban, Mexicar	igin? (Spec	cify Yes or No- Rican, etc.)	14. Race Black	- Americ c, White,	an Indian, etc.	
36	or It	by Fu	1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divord	Married 177 Yes If Yes, G	orces? 2 No 194 Dates: 196	3	1 ☐ Yes 2 🏋 No	Specify:			Specify:	Whi	to	
ö	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28e-f ehow uther then "natural", or Items 23a or 28e-f ehow ont, the Medical Exacultational Le notified at	ed p		dent's Education	Dates. 170	16a Dece	dent's Usual Occu	pation			16b. Kind of Bu			
15	in 72 in "na Wedis	piet	(Specify only hig Elementary/Secondary (0-12	hest grade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retire	e during mos ed)	t of workin	ng				
212	d with	Completed	12			Fi	rst Serg	7			United		es Ar	my
pu	be file tal Hy d oth event	Be	17. Father's Name (First, Midd	_					_{er's Name} e Nat		Maiden Sumame	9)		
yla	d Men d Men narke	^L	Leonard Ceric			19h Maili	ng Address (Stree				r. City or Town.	State. Zip	Code)	
Maryland 21215-0036	id 2 si Ith an 27 is r traur		Victor Ceric		on		ong Driv							
ē,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natuu eny injury or other traumatic event, Ita Madical once.		20a. Method of Disposition		20h P	 Place of Dispo semetery, cre	sition (Name of	ace)	Octob	er 1,	20c. Location -	City or To	wn, State	
ě	Page: sent o nt: If		1 🖾 Burial 2 □ Crematio 1 □ Donation 5 □ Other		n State Haj	rford ardens	matory or other of Memorial	1	200		Aberdee	n. M	ary1a	nd
Baltimore,	permit. Departir Importe eny inju		21. Signature of Funeral Serv	ice Licensee	*.	2	Name and Add	ress of Facili	ty Funer	als. P				0.2010000
8	8989		Donne	0 - B - V	luks	110	03_WSto	ockton	Stre	et, Ell	kton, Ma	ryla	nd 219	
			23a. Part1. Enter the disease shock, or heart failure.	i, or complications that List only one cause on	t caused the death each line.	h. Do not en	ter the mode of dy	ring, such as	cardiac of	r respiratory ar	rest,		Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	OPD								5yr	9
	/Medical Examiner		,	Due to	o (or as a conseq	_	renal	Fai	1	- 40			2 45	٠ د
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a conseq		10000	100	1 001				~ 1	
V	ate be executed hysician and ihe burial-transit	Examiner	Cause (Disease or injury that initiated events	5										
760,	le be executed ysician and e burial-transif		resulting in death) Last	Due to	o (or as a conseq	uence of):								
876	cate b	dicai		d									rana I	
89 x	Attending Physicien: The law requires that the death certificat reath. r death. setor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE:		outcome of pregna						23d. Date	e of delive	ery	
Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	e birth 2□Feta gnant at time of d		DEctopic pregnan Other (specify)	icy			Mor	nth	Day	Year
0.	that the death ed by the atte detached for	hys	9 🗆 Unknown	9 Unl										
s, P	signed be det	by P	Part II. Other significant con-	ditions contributing to	death but not res	sulting in the t	inderlying cause g	given in Part	l.	23e. Did to	obacco use contr / /es 2 □ No		ne cause of pably 4 🗍	
ord	n requires been sign should be	ted								-				
Records,	e law has b je 2 si	Completed								24a. Was autop perfo	rmed?	rior to co eath?	psy findings impletion of	
a	i cien : Th certificate rector, pag		25. Was case referred to med	dical			_	26 Place	o of Death	1 Yes		Yes	2∐ No	
Vital	ysicien: The lav is certificate has director, page 2	To Be	examiner? 1 Yes 2 No	Hospital:	☐Inpatient 2☐	ER/Outpatie	nt 3 DOA)th an	ursing Hon		dence 6 Othe	ar (Specil	(v)	
l of	ding Phys h. After this funeral di	T ::	27. Manner of Death	28a. Dat	te of Injury onth, Day Year)	28b. Time o	of 28c. Inj	ury at lork?	2	28d. Describe h	now injury occurr	ed		
ior	anding Path.	atio	Z () NOOIGON	estigation			M 1[Yes 2						
Division of	or Attender de Directe	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	uld not be termined 28e. Pla bui	ice of Injury - At he Iding, etc. (Specif	ome, farm, si fy)	reet, factory, offic	8	2	28f. Location (S City or Tov	Street and Number vn, State)	er or Rura	al Route Nur	nber,
Ω	To the Hospitel or Attenwithin 24 hours after deatl to the Funeral Director: completely filled in by the		29a, Certifier 1 Cert	ifying Physician: To t	the best of my kno	owiedne, dea	th occurred at the	time date a	nd place, a	and due to the	cause(s) and ma	nner as s	tated.	
	24 hc 24 hc 5 Fun etely	edicai	(Check only 2 Medi	ical Examiner: On the	basis of examina anner stated.	ation and/or in	vestigation, in my	opinion, de	ath occurre	ed at the time,	date and place, a	ind due t	o the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of cer	rtifier			29c. Lice	nse number			29d. Date signed	(Month,	Day, Year)	
			1 Jose /	VVa			DL	1471	6	5	epten	uper	26,2	005
	6+1		30. Name address of per	son who completed ca	ause of death (Iter	т 23а) (Туре								
	0		31. Date filed (Month, Day, Y	V/a 111 (. Radistrar's Signa	12 St	/ Elh	c tom	N	10				
	St Regist	ate raŗ	Coate med (Mortin, Day, 1	0 3 2005	Jane and a	10	carles							
_	•		V-Q-1	0 0 6000	BANKET STEERS AND THE STEERS	Section 1								

DHMH 17 Rev 1/2001

CERICOLE, VICTOR

			For State Registrar Ame	end Item	State o	FH g85	а/ Dep 3 3/0 €	artmeni 706a	nof De	aith and i eath	Mental Hy	gien Reg. N	71115	31951
	Physici	an	1. Decedent's Name ((First, Middle, L	ast)						2. Date of De Month		ay Year	3. Time of Death
	/Medic		Hilda Amy								Septem		24, 200	5 12:00 P ^M
	Examin		4a. Facility Name (If n					4b. City,	Town, or Lo	cation of Death	1	4	c. County of Deat	h
			Glade Vall	Ley Nurs					rsvil				rederick	
	Funeral Director		1.35 Security Nur 145-12-589	95	Sex 1□M 2ĬŬF	7. Age (In yrs.	8 Yrs.	Months		Under 24 Hrs. lours Min.	(Month, Da	rth ay, Yea 5 , 1	9) 9) 9) 9) 9) 9) 9) 9) 9) 9) 9) 9) 9) 9	hplace (State or Foreign ountry) Jersey
	and **	-	Usual Residence of D	ecedent 10b, County		10c, Cit	ty, Town or L	ocation						10d. Inside City Limits
	deeth with the Maryland ms 23a or 28a-f show rmst be notified at	้อ	New	,										1 ☐ Yes 2 No
	28a-	Director	Jersey E	ESSEX		Vero	na	10f, Zip	Code			100.0	citizen of What Co	ountry?
	23a or							0704					mileon of What oo	
	ns 23a must 1	era	16 Lynwood	i Koau	12. Was Dec	edent Ever in U	.S. 13.			nic Origin? (S		USA 	14. Race - Ame	rican Indian,
36	after or Ita	by Funerai	1 ☐ Never Married		Armed Fo	rces? 2 ሺ No ve			ofy Cuban, N 2∭2 No S		pecify Yes or No Dican, etc.)		Black, White Specify:	e, etc.
Maryland 21215-0036	"natural",	ted	1	5. Decedent's E	ducation		16a. Dece	edent's Usua	I Occupation	n		16b.	Whi Kind of Business/	
15	n n	Completed	(Specify Elementary/Second	only highest g	rade completed) College (1.40r E 1\	(Give	e kind of wor DO NOT us	rk done durir se retired)	ng most of wor	king			,
212	TIPE	E	12	Jaily (U-12)	College (1-401 5+)	Telle	r				Ban	king Ind	lustry
b	ba filad ital Hygir id othar event, II	Bec	17. Father's Name (Fi	irst, Middle, Las	t)				18.	. Mother's Nan	ne (First, Middle	, Maide	n Sumame)	
lar	Q 22 D		John Shaw						$ _{\Gamma^{\prime}}$	vdia B1	ack _			
ary	s 1 and 2 should I Haalth and Man Itam 27 Is marke other traumatic		19a. Informant's Nam	ne/Relationship	(Type, Print)		19b. Mail	ing Address		The second secon		er, City	or Town, State, Z	Zip Code)
	rt 2		Beberly C.	Morter	ison, da	ughter	16 Ly	nwood	Road	Veron	a. New	Jers	sev 070	44
Ore	gas 1 au it of Haa if Itam or othe		20a. Method of Dispo	sition		20b. F	Place of Disp	osition (Nam	ne of	1	Date		Location - City or	Town, State
Ĕ	Pages nent of int: if I		1 ☐ Burial 2 🔼			State	-	-		y	6/2005	Smi	thsburg,	Maryland
Baltimore,	parmit. Pag Dapartmant Important: I any injury o		21. Signature of Fund	eral Service Lice	эпэрээ			-						neral Home
8	20 E 2 8		Kua	uMJ	Deran	MO							erick, M	
	100		23a. Part1. E der the	disease, or cor	nplications hat o	aused the deat	h. Do not er	ter the mode	e of dying, s	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Carse (Fi		1000	roscle	entin	Conli		Take 1997				Onset and Death
	/Medical		resulting in death)	-		(or as a conseq		CHIUL	JVASCU	Tar Dr	sease			Years
	Examiner		Sequentially list cond	litions	ь. Нуре	ertensi	on							Years
	D #	iner	Sequentially list cond t any leading to immo cause. Enter Underly Cause (Disease or in	recliate /	Due to	or as a consac	uence of							
V	and and trans	Examiner	that initiated events resulting in death) La		C	·								
60,	raquiras that the death cartificate be axecuted ean signed by the attending physician and nould be datachad for usa as the burial-transit	Ē	, , , , , , , , , , , , , , , , , , , ,	"	Due to	or as a conseq	uence or):							
68,760,	cata h	ledicai			d			<u> </u>						
	ding p		IF FEMALE:		23c If yes out	come of pregna	ancy				1	- 1		
Вох	eath cart attending for usa	Physician/N	23b. Was decedent p in the past 12 m	onths?	1 Live b	oirth 2 ☐ Feta nant at time of d	death 3	☐Ectopic pre☐ Other (spe					23d. Date of deli Month	very Day Year
0	at the de by the a	ysic	1 □ Yes 2 🔯 I 9 □ Unknown	No	9□ Unkn		5	_ Outer (spe	sciry)					
<u>α</u>	that and by data	P.	Part II. Other signification	ant conditions	contributing to d	eath but not res	ulting in the	underlying ca	ause given ir	Part I.	23e. Did 1	obacco	use contribute to	the cause of death?
Vital Records,	uiras sign	d by	Dementia								1 🗆	Yes 2	2 X No 3 □ Pro	obably 4 Unknown
Ö	> 0 50	ompieted						-			24a. Was	an	24b. Were au	toosy findings available
Re	The law ita has b baga 2 sl	ш									auto perfe	psy ormed?	death?	topsy findings available completion of cause of
a		CO	25. Was case referred	d to madical	(DI 4 D	1 Yes		o 1 ☐ Yes	2 No
5	Physician: this cartific ral diractor,	00	examiner?		Hospital:	Inpatient 2	EB/Outpatio	nt 3 □ DO	0.1		th (Check only o		6 □Other (Spec	
of		7: To	27. Manner of Death			of Injury th, Day Year)	28b. Time o		8c. Injury at Work?	*251 Nuising H	28d. Describe			ary)
ion	Attending r death. sctor: After	tio	1 XNatural 2 ☐ Accident	5 Pending investigation		(h, Day Year)	Injury	м		2 🗆 No				
Division	Atter r daa ector by the	ertification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	280. Place	of Injury - At h	ome, farm, si	reet, factory,	, office		28f. Location (Street a	nd Number or Ru	ral Route Number,
Ö	s afta	Cert	4 Notticide		buildi	ng, etc. (<i>Specil</i>	у)				City or To	wn, Stat	тө)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai (29a. Certifier 1 (Check only 2 one) 2	Certifying P	miner: On the b	best of my kno asis of examina ner stated.	wledge, dea tion and/or in	th occurred anvestigation,	at the time, of in my opinio	date and place, on, death occur	and due to the red at the time,	cause(: date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and tit	le o certifier	1			29c.	License nu	mber		29d. D	ate signed (Month	n, Day, Year)
			•	ALL	19			D2	26516			Sen	tember 2	7. 2005
			30. Name and addres	s of person who	completed caus	se of death (Item	n 23a) (Type	1		. Gilso	on, MD	peb	CCMDEL Z	., 2003
	6		1475 Tane		#204,	Freder	cick,	Maryla	and 2	1702	-,			
	Sta Registr	40.0	31. Date filed (Month)	CT Cars	2005	egistrar's Signa	ture A	aster!						

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 9/14/2005 4:00 a^M Bashiruddin Druitt /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6 / 14 / 1967 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F 579-82-6556 38 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Heelth and Mental Hygiane. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified as any injury or other traumatic event, the Medical Examiner must be notified as any injury or other traumatic event, the Medical Examiner must be notified as any once. Hyattsville 1 ☐ Yes 2 No Prince Georges Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7215 East Ridge Dr. 20785 Completed by Funeral $U_{\bullet}S$ S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none 12 unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Zayd Ahmad Carol Whitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Čity or Town, State, Zip Code) Zayd Ahmad/ father 5018 4th St., N.W. Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md Washington National 9/17/05 21. Signature | Funeral Service | Inser 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo Cardial **Physician** HYC /Medical Due to (or as a consequence of): Examiner tear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cor Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 2 Onknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Hamai has Vival certificate Suppressiv 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?
1 □ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To ţ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 024720 9-15-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVINDER RELLITAGI MID LANDOVER ROSD MO CHEVER LY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 19 SEP 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2005

			For State Registrar	State of Mary	land / Depa <i>Cer</i>	artment of F <i>tificate of</i>	dealth and Death		en & UUD	31953
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
П	Physici: /Medic	_	Robert Warren Del	3oard				Sept. 9,	2005	6:22 P M
)	Examin		4a. Facility Name (If not institution, giv	e street and number)			or Location of Dea		4c. County of Dea	
			Calvert Memorial	-			Frederic		Calvert (
e e	Funeral Director		376-24-3000	Sex 7. Age (In 79	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1925 Was	thplace (State or Foreign shington, DC
	ryland thow		Usuaf Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 X No
	e Ma	cto	MD Calvert	County	Lusby					
	or 24	Dire	10e. Street and Number	D 1		101. Zip Code		10	g. Citizen of What Co	ountry?
	sath v	rai	9551 H.G. Truemar	12. Was Decedent Ever	in II C 112 1	20657	dienania Origina /	Specify Vos or No.	U.S.A.	erican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	Amed Forces? 1 XYes 2 □ No #Yes, Give Year or Dates:		f Yes, specify Cub		Specify Yes or No- to Rican, etc.)	Black, Whit	e, etc.
5-0	72 ho natur	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	orking 1	6b. Kind of Business	/Industry
2	ofthin han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			nd)		Optical Co	2000 DT7
7	iled w Hygiei ther ti	S	10 17. Father's Name (First, Middle, Last)	Opti	cian	18 Mother's Na	me (First, Middle, M		лірапу
and	d be f	o Be		,						
Maryland	should nd Me mark matic	٦	Robert DeBoard 19a. Informant's Name/Relationship	Type, Print)	19b. Mailin	ng Address (Street		lizabeth ural Route Number,		Zip Code)
<u>S</u>	nd 2 sulth ar		Nancy A. Lawrenson	n (Daughter	9551	H.G. Tru	eman Roa	d, Lusby,	Maryland	20657
ē,	s 1 ar		20a. Method of Disposition	2	Ob. Place of Dispo			Date 2	0c. Location - City or	
Ë	Page nent o nnt: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State (fy)	Maryland	Vets. Ce	m. sept			Maryland
Baltimore,	permit. Departmine imports any inju		21. Signature of the Service Lice				ess of Facility ${f L}{f c}$	e Funeral		vert, P.A. MD 20736
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	oplications that caused the	death. Do not ent-	er the mode of dyi	ng, such as cardia	c or respiratory arres	st.	Approximate fnterval Between
	Physician		fmmediate Cause (Final disease or condition	a CARDIO	000000	A TORY	ARRES	Τ		Onset and Death
	/Medical		resulting in death)	Due to (or as a co		1, 1001	PRILES			
老	Examiner		Sequentially list conditions, if any, feading to immediate	O END S		RENA	- DISI	2ASB		
	pe tisi	Examiner	if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co		~				
	xecut end Il-tran	хап	that initiated events resulting in death) Last	c. 3SCITEN	nsequence of):	DRDO	MAOB	YUTA		
9	ficate be executed physician end is the burial-transit		l l							
68760,		edical		d						
Вох	n certi		IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of p		Ectopic pregnanc			23d. Date of de	livery
9.0	The law requires that the death certif ste has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year
P.O.	hat th d by detach	Phy	Part II, Other significant conditions	contributing to death but no	nt resulting in the ur	nderlying cause giv	ven in Part I	23e. Did toba	acco use contribute to	the cause of death?
ds,	uires tha signed d be dei	d by	HADERTENSI		a rosalling in the di	radifying oddab gi	voit in a contra			robably 4 Unknown
Ö	w require been sig should b	etec						24a. Was an		utopsy findings available
Rec	: The law cete has t	Completed	HABERTIBIE	16 W 16				autopsy perform	ed? prior to death?	completion of cause of
ā			25. Was case referred to medical				26 Place of Do	1 ☐ Yes 2 eath (Check only one		2 □ No
Š	s cert	To Be	examiner? 1 \(\text{Yes} 2 \) No	Hospitaf:	2 R/Outpatien	t 3□ DOA Ot	han	Home 5 Resider		icity)
0	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of			28d. Describe how		,,
<u>ö</u>	Attendin death. ctor: Aft y the fun	atio	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation		a) injury		Yes 2 □No			
Division of Vital Records,	i or Atte after de Directo	Certification:	3 Suicide 6 Could not to determined		At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	Contier 1X Certifying Fl (Check only 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	y knowledge dealt mination and/or in	cocumed at the tive states at the tipe of the states at the tipe of the states at the	ine, data and plan opinion, death occ	e, and due to the nav urred at the time, dat	ise(s) and manner at te and place, and dur	s troiled e to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and rule of certifier			29c. Licens	se number	29	d. Date signed (Mon	h, Day, Year)
			> pully	M.D.		D62	2288	0	1/12/20	05
	2+1		30. Name and address of person who	ON LINCOLT	al Pin	Print)	INCE C	PREDERI	- m u	20678
9	Sta		31. Date filed (Month, Day, Year)	32. Registra 5	Signature	frank.	5	1-LUZIKI	27.10	010
1	Registr	ar	SEP 1	4 4 4003 7 10	BACI JU	PROPERTY.	5			

		4	1 - State Of State Of Registrar		ertificate of Death	Mental Hygie	2003 31334
	Physicia	an	1. Decedent's Name (First, Middle, Last) Vera Elizabetl	n Donal	ldson	2. Date of Death Month September	3. Time of Death 12:07p M
	/Medic Examin		4a. Facility Name (If not institution, give street and nur. 2150 Mike's Way		4b. City, Town, or Location of De		4c. County of Death Calvert
	Funeral Director			7. Age (In yrs. last birthday 86 Yrs.			ear) 9. Birthplace (State or Foreign Country) 1919 Maryland
	ryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the Ma or 28a-f	Directo	MD Calvert 10e. Street and Number		ings 10f. Zip Code 20736	10g	. Citizen of What Country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other treumatic event, the Medical Example in unit be notified at	by Funeral Director	2150 Mike's Way 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes If Yes, Giv Year or D	rces? 20 No	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hou ene. then "nature ne Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	16a. Dec (Giv	edent's Usual Occupation e kind of work done during most of v DO NOT use retired) homemaker	vorking	own home
and 2	ld be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles Quigley			lame (First, Middle, Ma	
Mary	nd 2 shou lith and M 27 is mar r treumati	-	19a. Informant's Name/Relationship (Type, Print) Jean E. Corcoran, daughte		ling Address (Street and Number or Mike's Way, Owin		City or Town, State, Zip Code) 1736
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other ti		20a. Method of Disposition 1 XI Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Special)	State	position (Name of ematory or other place)		c. Location - City or Town, State
Balti	permit. Departminents imports eny inju		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		Owings, MD 20736
	Physician		23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on elimmediate Cause (Final disease or condition				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to Sequentially list conditions, b.	consequence of:	tory ATheros Heart Failure		Syears
8760,	cate be executed physician and the burial-transit	ai Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):			,
.O. Box 687	ne death certifi the attending I thed for use as	Physician/Medicai	is the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	es that igned b	by	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown
al Records,	The law ate has b page 2 sl	Completed					24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Vital	Physician: This certifical director, p	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2\(\subseteq \text{No} \) Hospital:	Inpatient 2 ☐ ER/Outpati	Othor	Death <i>(Check only one)</i> The Home 5X Residence	ce 6 Other (Specify)
ion of	Per Jel	tion: T	27. Manner of Death 28a. Date	of Injury th, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how	
Division	et or Attending s after death. if Director: After id in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, sing, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or I within 24 hours after To the Funeral Dire completely filled in b	Medical ((Check only 2 Medical Examiner: On the b		ath occurred at the time, date and plainvestigation, in my opinion, death or		se(s) and manner as stated. a and place, and due to the cause(s)
)	To the within 2 To the complete	W	29b. Signature and title of certifier	(inn	29c. License number D0030484	29d	Date signed (Month, Day, Year)
	6		30. Name and address of person who completed cause Charles A. Umose 1/3	,		1 Oxon H	:11, mp 20745
	Sta Regist						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day September 15, Lee Estep 2005 5:03 p Janet 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Hours 1 □ M 2 X F 54 February 19, 1951 Washington, DC 220-58-7763 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Maryland Prince George's Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Elm Avenue 20912 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Claims Operator Liberty Mutual 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Proudfoot Evelyn G. Kester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Elm Avenue, Takoma Park, Maryland 20912 John E. Pross - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 09/18/2005 Alexandria, Virginia 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction hour Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Lung cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dementia Behavior Disturbances 1☐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 📉 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide i 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057630 SATT. 16, 2005 Cun M. ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue, Suite 209, Silver Spring, MD 20902 Anuradha Arun, M.D. 31. Date filed (Month, Day, Year) 82. Registrar's Signature

State Registrar

e Hospital or Attending Pl 24 hours after death Funeral Director: After t

To the within 2 To the

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Directo

by Funeral

Completed

Be ို

permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Interpretate if item 27 is marked other than "natural", or items 23a or 28a-f ahow many injury or other traumatic event, the Medical Evernitational by routilise at 2002.

Peges 1 end 2 ment of Health a ant: if item 27 is

Physician

/Medical

Examiner

the attending physician and hed for use as the burial-transit

detached

Division of Vital Records, P.O. Box 68760,

Examiner

δ

Be

Certification: To

Medical

SEP 2 0 2005

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year James Whitlock Embrey September 13, 2005 12:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 226-60-9230 61 1944 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes X☐ No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with United States 732 Lazy River Road 20657 death 1 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify Specify. δ 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n 27 is marked other than ".

'y traumatic aven" Elementary/Secondary (0-12) College (1-4or 5+) 5+ Archaeologist Archaeology Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James William Embrey Myrtle Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is any injury or other traugonce. Mary Embrey (Wife) 732 Lazy River Road, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 9/14/2005 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. BRound 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Minknown Be Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical example? funeral director, 26. Place of Death (Check only one) Other: 2□ No Certification: To 1 Yes 3 0 OA 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Matural within 24 hours after death. To tha Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30.-Name and address of person who impleted cause of death (Item 23a) (Type, Print) 10 W 32 aymon JODIE 31. Date filed (Month, Day, Year) SEP 1 5 2005 32. Registrar's Signature State Registrar

			State of Maryland / Department	artment of Health and Mei	ntal Hygien	e
				rtificate of Death	Reg	<u> 2005 31958</u>
	Physici	200	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month D	3. Time of Death
	/Medic		Francis Ehrenreid		eptembe:	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			1205 East Raymond Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Indian Head If Under 1 Year If Under 24 Hrs. 8	Date of Birth	Charles 9. Birthplace (State or Foreign
	Funeral Director		186-12-7303 ¹ X M 2□F 81 Yrs.	Months Days Hours Min.	(Month, Day, Year) h 26.19	r) Country)
	D		Usual Residence of Decedent			
	anylar ehow	_	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ☐ Yes 2 ဩNo
	18a-f	ectc		n Head 10f. Zip Code	100 0	itizen of What Country?
	a or	Oir	1205 East Raymond Ave.	20640	109.0	
	death with the Maryland ms 23a or 28a-f ehow	Funeral Director	11 Marital Status 12, Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify	Yes or No-	USA 14. Race - American Indian,
9	or Itan		Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto Ric	an, etc.)	Black, White, etc.
9	filed within 72 hours after Hygiene. other then "natural", or Ita ent, the Medical Exertitie	Completed by	3 N Widowed 4 Divorced Year or Dates:	A.		Specify: White
7	"natu	lete	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry
12	withii ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+)	ef Warrant Offic	er II	IS Marine Corps
2	be filed tal Hygid d other event, ti	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
lar		To B	Anton Ehrenreich	Elizabet	h Ehren	reich
Maryland 21215-0036	S as as			ng Address (Street and Number or Rural R		
	s 1 and 3 f Health Item 27 other tr			Hill Spring Dri		Location - City or Town, State
20	m 0		Multipliar 2 Cremation 3 Hemoval from State	matory or other place)	2001	
altimore,			*4 □ Donation 5 □ Other (Specify) Marylan 21. Signature of Funeral Service Licensee M0 0 9 4 5 23	d Veterans 9/22/	05 Che	ltenham, Maryland
Ba	permit. Departr Importa any Inju		David C Echil	REHART - ECHOLS FU	NERAL H	OME, P.A.
	1		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition DIA RE T	1		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	, ,		
k.	Examiner	h	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ted nsit	niner	cause. Enter Underlying Cause (Disease or injury			
	i be executed sician and burial-transit	Examin	that initiated events c			
8760	cate be executed physician and the burial-transit	dicai	d			
9		Med	IF FEMALE:			
Вох	death certifi e attending I id for use as	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
O	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		
ت	The law requires that the ate has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	w requires been sigr should be	ed by			1 ☐ Yes 2	2 No 3 Probably 4 Unknown
000	aw rec s bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
¥.	The lav	mo			performed? 1 ☐ Yes 2 X N	death?
ita I	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (C	heck only one)	
7	Physic this car	70	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			
Division of	ding F h. After funer	tion	27. Magner of Death	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Describe how inju	ary occurred
/ISI	l or Attend after death. Director: #	fical	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, str		Location (Street a	nd Number or Rural Route Number,
á	al or A s after il Direc	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Star	(9)
	e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letaly filled in by the funeral director,	edical (29a. Certifier (Check only (Ch	h occurred at the time, date and place, and	due to the cause(s) and manner as stated.
	To the h within 24 To the F complete	Medi	one) and manner stated. 29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	T X S		* 1 Tatt	N2435)_ (9/16/05
(•		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		(11 - 1 -)
1	D 10! 1		Krishan Mathur M.D. P.O. Box 1	703, La Plata, MD	20646	
	Sta		31. Date filed (Month SEP Pear) 9 2005 32. Resistrar's Signature	Sec. V.	-	
	Registr	ar	John John John John John John John John	Sarce .		

Please Type	or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

			• •	vland / Den		of Health and	Mental Hy	aiene	09.2.0.	
		1 - For State Registrar	Otato or mar	•		of Death		Reg. 2 (005	31959
· 建二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十		Decedent's Name (First, Midd	lie, Last)				2. Date of De.		Year	3. Time of Death
Physi /Med		John Warren	Frame III				SEPT	16	200	
Exam	iner	4a. Facility Name (If not institution			4b. City, T	own, or Location of Dea	ath		ounty of Deat	
Funda	⁶ }∂ ₂ •	5. Social Security Number		'In yrs. last birthday) If Under 1		s. 8. Date of Birt		10001 9. Birt	hplace (State or Foreign
Funera Directo		042-16-7975	XX M 2□ F	85 Yrs.	Months	Days Hours Mir	8. Date of Birt (Month, Da 02/21/	1920	Co	PA PA
pug *		Usual Residence of Decedent 10a. State 10b. Count	v 1	Oc. City, Town or L	ocation					10d. Inside City Limits
Maryla f sho	ō	MD Worce		Ocean C						1 XYes 2 □ No
ING ZIZIS-UUSO be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Items 23e or 28e-f show event, the Medical Examinat must be notified at	Funeral Director	10e. Street and Number	ester	Ocean C	10f. Zip C	Code		10g. Citize	n of What Co	ountry?
th with	a D	807 Boardwalk			218			USA		
er dea	nuel	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decede II Yes, specif	nt of Hispanic Origin? (y Cuban, Mexican, Pue	(Specify Yes or No irto Rican, etc.)	- 14	Race - Ame Black, Whit	
urs afte	by F	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give		1 🗆 Yes 2	No Specify:		Sį	pecify: W	nite
3-UUSO 72 hours after natural', or ite			nt's Education est grade completed)	16a. Dec	edent's Usual	Occupation	orkina	16b. Kind	of Business/	Industry
within 7 ene. than "r he Mad	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			done during most of w retired)	Grg			
iled w tygier ther th		17. Father's Name (First, Middle	Last)	Own	er/ Op		ame (First, Middle,	Hote Maiden Su		
id be fill ental H ked oth ic even	To Be	John Warren F				Alta I				
shoul and Meridian	-	19a. Informant's Name/Relation		19b. Mai	ling Address (Street and Number or F		ar, City or T	own, State, 2	Zip Code)
and 2 st and 2 st ealth and m 27 ie r		Susan Pilchard	d (daughter)			dale Ct. N				
Baltimore, Maryle sermit. Pages 1 and 2 should Department of Health and Mer mportant: if item 27 ie marke my injury or other treumatic		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 Removal from State	20b. Place of Disp cemetery, cre			Date		tion - City or	
Baltimo permit. Pages Department of Important: If I any injury or	اد	4 Donation 5 Other (Cape He	niopen 22. Name and	Crem. 09/	17/2005	Frank	cford,	DE
Department of the control of the con		Parajuli	no 4 Da			iam Street				ie
		3a. Part1. Enter the disease, of shock, or head failure. Lis	or complications that caused that only one cause on each line.							Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition		10 juin	Phone					Onset and Death
/Medica Examine		resulting in death)		consequence of):	25.4	T 1 L				1000
		S quentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequent e of):	~~~	In facto	<u></u>			124
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Con	my hoh	· Dw	بهف				Year,
ate be executed hysicien and he burial-transit		resulting in death) Last	Due to (or as a o	consequence of):					I.	
58 / 50 ificate be e g physicien as the buris	dical		d		· · · · · · · · · · · · · · · · · · ·					
X end	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outcome of					230	d. Date of del	ivery
	iciai	in the past 12 months?	1 Live birth 2		☐Ectopic pred ☐ Other (spec				Month	Day Year
thet the death ed by the atte	Phys	9 Unknown	9□ Unknown				00 8:44			
COTGS, F.C. w requires that the speed signed by the should be detected.	þ	Part II. Other significant condit			underlying cal	use given in Part I.		obacco use /es 2 🗆 !		the cause of death?
ecords law requires as been sign	etec	0	(10	hemi C	2	Jedin 2	24a. Was	T		itopsy lindings available
P P P P P P P P P P P P P P P P P P P	Completed	14 Almia		way body	- Olivery		autop perfo	rmed?	prior to death?	completion of cause of
(0	0	25. Was case referred to medic	al			26. Place of D	1 ☐ Yes eath (Check only o		1 🗌 Yes	2 No
OT VICA Physicien: this certific	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient	2 ER/Outpatie			Home 5 Resid	dence 6]Other (Spe	cify)
on or ding Phys h. After this tuneral dir		27. Magner of Death 1 Natural 5 Pend		(ear) 28b. Time Injury		c. Injury at Work?	28d. Describe t	now injury o	occurred	
Silent ten ton the	icat	3 Suicide 6 Could	I not be 28e. Place of Injury	- At home, farm, s	M street, lactory	1 Yes 2 No	281. Location (S	Street and N	Number or Ru	ural Route Number,
DIVI al or Al after of Direct	Certification:	4 Homicide	mined 288. Place of injury building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tov			
Hospitel or At 24 hours after Funerel Directeley filled in by		29a Centiler (Check only 2 Medica	ing Physician: To the best of a I Examiner: On the basis of ea	wy knowledge, des	It socured at	the time, date and plan	na, and duality the curred at the time.	date and of	d marinar as	stated
To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifit	and manner state			License number				h, Day, Year)
Mit To Cot		250, Signature and title of certific	ca de		250.	DAAOP		<		. 2005
		30. Name and ad ci person	n who completed cause of dea	th (Item 23a) (Type	a, Print) 👞 🔹			la d	A	0
.H. 6		2 choc		101 MILL	F- 80 - 1	200	AU 18-RY	וניו ,	ע עי	604
A CONTRACTOR OF THE	State strar	31. Date liled (Month, Day, Year SEP 2	0 2005 32. Tegistrar's	s Signature	had,					

			For 1 State	State of M	•		artment of				00	205	01060	
			RegistraMFND#28cperM 1. Decedent's Name (First, Middle, Li		MbCo	Cei	uncate c	Deali		Re 2. Date of Death	g. Nø.	102	3. Time of Death	_
	Physicia	an		151)	70		FREY			Month	Day	Year	M	
	/Medic		KATHERINE 4a. Facility Name (If not institution, gi	ve street and numbe	A.			n, or Location		eptembe		unty of Deat		_
	Examin	er	18700 WALKERS C			208	200000000000000000000000000000000000000	SOMERY		GE.	M	ONTGON	ÆRV	
	Funeral		Social Security Number 6.	Sex 7.		last birthday)	If Under 1 Ye Months Da	ar If Under	24 Hrs	Date of Righ		O Die	hplace (State or Foreign	7
	Director		327-18-7475	1 □ M 2 💢 F	85	Yrs.	Months	ys Hours	IVIET.	Month, Day, Sept. 8	192	0 Ĩ	llinois	
	PG ≹		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits	_
	sho	ត	Md. Montgo	omerv		•	mery Vi	llage					1 ☐ Yes 2 🖫 No	
	28a-1	ect	10e. Street and Number				10f. Zip Cod			10	g. Citizer	n of What Co	untry?	_
	with 3a or		18700 Walkers Ch	noice Road	ł #2	208		2088	6		Un:	ited S	tates	
	hours after death with the Maryland lural', or Items 23a or 28a-f show al Examinating Leinvillied at	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	l.S. 13.	Was Decedent of Yes, specify C	of Hispanic Or	rigin? (Spec	ify Yes or No-	14.	Race - Ame Black, Whit	rican Indian,	
စ္	or Ite	E.	1 ☐ Never Married 2 ☐ Married	1 Tes 2		İ	1 ⊡ Yes 2 🔀 i			ican, etc.)	So		hite	
5-003	ural',	d by	3 ₩ Widowed 4 Divorced	Year or Date	S:									
<u>.</u>	"natu	Completed	15. Decedent's l (Specify only highest g	Education rade completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during mos	st of working	7	6b. Kind	of Business/	Industry	
2121	within 72 ene. than "nal	diuc	Elementary/Secondary (0-12)	College (1-4d	r 5+)		an Offi	,			Cı	redit	Union	
დ დ	filed Hygir other ent, I	Be Co	17. Father's Name (First, Middle, Las					18. Moth	er's Name	(First, Middle, M		mame)		
<u>a</u> n	ould be to Mental I warked of watic eve	To B	Fred Arends					My	rtle	Will:	iams			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show among injury or other traumatic event, the Madical Examinar must be notified at ance.		19a. Informant's Name/Relationship							Route Number,				1
	and 2 ealth n 27 I		Marilynn J. Frey	/ Daught									ve,Md.20880	,
Baltimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta	te (cemetery, crei	sition (Name of natory or other	place)	Da			tion - City or		
Ħ,	rtmen rtant:		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 		Me		itan Cr		9/17			andria	, va.	-
Bal	permit. Departr Importa		21. Signature of Funeral Service Lice	BAN		24				Funeral			2222	
			23a. Part1. Enter the disease, or co	mplications that caus	ed the deat	th. Do not ent				Laytons' respiratory arre		e, Ma.	Approximate	_
	Dhamisis		shock, or heart failure. List onl Immediate Cause (Final	-			-000	0.00	+				Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consec	guence of):	" was	2000					seconds	2
	Examiner		O dell'article distance	, mu	Hip	le or	Sans	syste	m -(ailure	_		weeks	
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_	as a consec			- J					1.00	
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to /or	10000	_ CIC	mey	- di	sea	se			chear)	
8760,	icate be executed physician and s the buriat-transit			Hera	70 (kns'i	00						22000	
687	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical		q. 11.21		01.31							3000	_
Box (eath certific attending p I for use as 1	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							230	I. Date of del	ivery	
	death e atte	iciai	in the past 12 months? 1 \(\sumeq\) Yes 2 \(\sumeq\) No	1 ☐ Live birth	at time of o]Ectopic pregna] Other (specif)					Month	Day Year	
P.O.	that the de led by the a detached f	hys	9 Unknown	9□ Unknowr	1									
	taw requires that the as been signed by th 2 should be detache	by F	Part II. Other significant conditions	contributing to deat	n but not res	sulting in the u	nderlying cause	given in Part	1.		- 1		the cause of death?	
ord	equir sen si lould	ted								1 □ Ye	s 2791	V0 3∐F1	obably 4 Unknown	_
Vital Records,	has bu	Completed								24a. Was ar autopsy	/	24b. Were au prior to death?	utopsy findings available completion of cause of	1
E H	Th ate pag	Co								perform 1 Yes 2	No	1 Yes	2□ No	
Žį.	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1500		Other		(Check only one		701 (0	-:()	1
oţ	Physic Ir this sral di	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of I	njury	ER/Outpatier 28b. Time o		njury at Work?	lursing Hom	e 5X Reside Bd. Describe ho		Other (Spe ccurred	city)	1
ion	Attending F r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury		Work? 1 ☐ Yes →	-					
Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine	Zoe. Flace of	Injury - At h	nome, farm, sti	reet, factory, off	ice	2	Bf. Location (Str City or Town		lumber or Ri	ural Route Number,	
Ö	ital or A rs after al Directed in by													
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Ex	Physician: To the be aminer: On the basi	s of examina									
	To the P within 24 To the C complete	Med	29b. Signature and title of certifier	and manner	Stateo.		29c. Lic	ense number		29	d. Date s	igned (Mont	h, Day, Year)	
•			Mex	2 Ful	160	nen	0	006	280	00	9/1	16/20	065	
•	10		30. Name and address of person wh	o completed cause of	of death (Ite	m 23a) (Type,	Print)				• 1	- 1 -		
				MD 197	ell Ho	ntgorn		age An	2#	Bloc M	ophre	ny V	illage, tun	,
	Sta		31. Date filed (Month, Day, Year)	32. Rec	strar's Sign	ature	GOLALL				3)	7659	Y
	Regist	rar	SEP 1	9 2005	Charles		F							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 1:55 a M **Physician** 21, 2005 SEPTEMBER GOLDIE GLADYS FOGLEPOLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **GARRETT** GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1□M 27 F OCT. 22, 1914 WV Director 212-38-6563 Usual Residence of Decedent 10d. Inside City Limits with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Cepardment of Health and Mental Hygiene.
Ill portant: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other fraumatic event, the Moulest Examiner must be notified at a me. 10a State 10c. City. Town or Location XXYes 2 No Director MT. LAKE PARK GARRETT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21550 221 SENECA AVENUE by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ② No Specify: Specify: WHITE Baltimore, Maryland 21215-0036 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 8TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALMA PEARL LEE JAMES MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 2039, MT. LAKE PARK, MD 21550 ERNEST FOGLEPOLE-SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) PLEASANT VALLEY CEM. 9/23/05 CAKLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility P.O. BOX 243 BURDOCK-DURST FUNERAL HOME OAKLAND, MD WOOCK 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of): Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 known -oan Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ZW0 Attending Physician: After this certification 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No. Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 9,21,5 9/21/05 D23979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oakland, Md. 21550 311 N. 4th St. Robert A. Goralski 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health and Mental Hygierie 0 5 State of Maryland / Department of Health Andrew / Department of Health Andre 31962 2. Date of Death 3. Time of Death nt's Name (First, Middle, Last) **Physician** -15 /Medical treet and number) 4c. County of Death 4a. Facility Name (If not institution, give 4b. City, Nown, or Location of Death **Examiner** LU THUR 8. Date of Birth (Month, Day If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign 5. Social Security Number Sex 9. Funeral Months Days Min. Hours 100M 2□F -90-926 Yrs. Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. haside City Limits 10a_State or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Tes 2 No etimore Director 10g. Citizen of What Country? 10f. Zip Code eet and Number Itams 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other then "natural", or Ita ☐Yes 212No fYes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
(Bive kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) l Hygiene. other then " Elementary/accoriginary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Ma. 17. Father's Name (First, Middle/Jast) Be ပ Street and Number or Bural Route, Number, City or Town, State, 19b. Mailing Address ionship (Type: Zip Code) 668 permit. Pages 1 and 2 Department of Health a Important: If item 27 is Place of Disposition (A Date City or Town, State 20a. Method of Disposi 3 ☐Removal from State 1 Burial 2 Cremation 4 Dog 5 Other (Specify) uneral Service Licenses 22. Name acility 21. Signa ure of any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronay arte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rable SIRK percoal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit seks that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day ō in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached P.O. the 9☐ Unknown 9 Unknown þ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò pe 1 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 1 Yes 2 No certificate 1 Yes To the Hospital or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 1 Tes 200 No this 28a. Date of Injury (M nth, D Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Certification Natural 5 Pending investigation 1 Yes death. 2 Accident in by the Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier the basis of axa-manner stated. nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature an title of

Registrar

State

Stree

32. Registrar's Signature

30. Name and address of person who completed (a) se of death (Item 23a) (Type, Print)

0 3 2005

31. Date filed (Month, Day, Year)

0005565

01

2120

			Sta State	te of Maryland				ind Menta	l Hygiene	200-	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2 Dot	Reg. No.	2005	31963
	Physicia		Edward, William.	Germani	7			Moi	nth Day	Year 200 C	10:35 P M
	/Medic Examin		4a. Facility Name (If not institution, give street a		, ,	4b. City, Town,	or Location o			County of Deat	
			University of Mayyla	a Medical	345	lans L	altin	orp M	D		
n	Funeral Director		5. Social Security Number 6. Sex 1 1 M M 2 [7. Age (In yrs. last	birthday) Yrs.	If Under 1 Yea Months Days			e of Birth oth, Day, Year) S• 1, 19	9. Birtl Co Mar	hplace (State or Foreign untry) Vland
	ס		Usual Residence of Decedent					1148	, -, -,	JJ Har	June
	show	5	10a. State 10b. County	10c. City, T		ocation					10d. Inside City Limits 1 ☐ Yes 2√XNo
	the M	recto	MD Anne Arunde 10e. Street and Number	1 Dea	ale	10f. Zip Code			10g Citi	zen of What Co	
	h with	i Di	6038 Drum Point Road				0751		, og. o	USA	unity.
	ems 2	Funeral Director	11. Marital Status 12. Was	s Decedent Ever in U.S. led Forces?	13.	Was Decedent of	Hispanic Orio	gin? (Specify Ye	s or No-	14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any Injury or other treumatic event, If a Modical Extending the notified at once.	by Fu	If V	Yes 2□No es, Give ir or Dates: 1954—!		1⊡Yes 2∏ No		,		Specify:	White
21215-0036	2 hou		15. Decedent's Education	1	6a. Dece	dent's Usual Occi			16b. Ki	nd of Business/	Industry
218	ithin 7 ne. nan "n	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Col	lege (1-4or 5+)	life.	kind of work don DO NOT use retir	e during most ed)	of working			
	iled w Hygier ther th		10 17. Father's Name (First, Middle, Last)		Supe	erintend		r's Name /Fint	Middle, Maiden	onstruc	tion
Maryland	d be f ental } ked of c eve	To Be	Eugen Germann					ouise In		Sumame)	
ary	shoul and Ma s marl umati	-	19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailir	ng Address (Stree				r Town, State, Z	(ip Code)
	and 2 salth a n 27 li		Mary Ann Germann (Wi			Box 58,	Deale,	, MD 207	51		
Baltimore,	iges 1 it of H it itel		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remova	from State ceme	etery, crei	sition (Name of matory or other pi		Date		cation - City or	Town, State
Itin	artmer artmer ortent Injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Let s • 9	Ft.	T .	oln Ceme			5 Bre	ntwood,	MD
Ba	Depa Impo any ir		13- 2. CM	_	ŀ	lardesty 2 Ridge	Funera	al Home,	P.A.	MD 214	01
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only doe caus	that caused the death. [e on each line.						217	Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition resulting in death)	ische.	mi(Card	ions	poth	5		Onset and Death
	/Medical Examiner		D. D. D. D. D. D. D. D. D. D. D. D. D. D	ue to (or as a consequen	ice of):						
	7 =	ner	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequen	ice of):						
	ecuted and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
8760,	cate be executed physician and the burial-transit	cal E		ue to (or as a consequen	ice or):						
9	E P	₽	0.				-			-	
Вох	death certific e attending p id for use as	an/N		es, outcome of pregnancy		Ectopic pregnan	cv			23d. Date of deli	
0.	0 0 0	Physician/Me	1 Type 2 TNo	Pregnant at time of death Unknown	h 5[Other (specify)				Month	Day Year
s, P.	de de	by Ph	Part II. Other significant conditions contributing	g to death but not resultin	ng in the u	nderlying cause g	oven in Part I.	23	a. Did tobacco u	se contribute to	the cause of death?
rds	w requires been sign should be		Congestive heary	failure					1 🗆 Yes 2 🤇	□No 3□Pro	obabiy 4 \QUnknown
Record	aw as b	ompleted						24	a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>=</u>	Th ate pag	Con						1	performed? Yes 2 No	death?	2 No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No Hospital	. North Allen	10		ther	of Death (Checi			-
of		1	27. Manner of Death 28a.		Outpatier b. Time o	f 28c. lnj	4 Nul		Residence 6		oity)
sior	Attending I r death. ector: After by the funer	catio	1 Natural 5 Pending 2 Accident investigation	(Monar, Day 1 ear)	Injury		Yes 2□N	No			
Division	of or Attency after death Director:	ertification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	•		ation (Street and or Town, State)		ral Route Number,
	To the Hospital or vithin 24 hours after Yo the Funerel Direction Completely filled in b	O	29a. Certifier 1 Certifying Physician:	To the best of my knowle	dge, deat	h occurred at the	time, date and	d place, and due	to the cause(s)	and manner as	stated.
	the Ho in 24 l the Fu pletely	edicai	one) 2 Medical Examiner: Or	the basis of examination d manner stated.	and/or in	vestigation, in my	opinion, deat	h occurred at th	e time, date and	place, and due	to the cause(s)
	With To To	Σ	29b. Signature and title of certified	1 / m/			nse number	<i>~</i>		e signed (Month	n, Day, Year)
			30. N he and address of per on who complete	d cause of death (Item 23	Ba) (Tyne	HU41	76435	SK1581	2 9/	8/0)
			22 S. Greene St	Baltino		MO	2120) /			
0	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		1 -		-			
	Registr	ar	SEP 1 4 2005	poster 1	1						

			1 - State of Maryland / Dep	partment of Health and Me ertificate of Death	ental Hygien	
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) Dorothy Irene Graves	S	Sept. 10,	3. Time of Death 7:00 A M
	Examin		4a. Facility Name (If not institution, give street and number) 70 Hazel Way	4b. City, Town, or Location of Death Sunderland () If Under 1 Year If Under 24 Hrs. 5		c. County of Death Calvert
L	Funeral Director		5. Social Security Number 577-32-7429 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb 12, 1	9. Birthplace (State or Foreign Country) 1928 New York
	Maryland a-f show	tor	MD Calvert Chesar	ocation Deake Beach		10d. Inside City Limits 1 ☐ Yes 2∑ No
٠	h with the 23s or 28s	Funeral Director	10e. Street and Number 8251 Moffet Run	10f. Zip Code 20732	10g. C	Citizen of What Country? USA
036	72 hours after death with the Maryland natural', or Items 23s or 28s-f show Jissi Evaciner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2⊠ No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation le kind of work done during most of working DO NOT use retired) Budget Analyst	g	Kind of Business/Industry Federal Government
Maryland 2	2 should be filed and Mental Hygis is marked other raumatic evant, I	To Be C	17. Father's Name (First, Middle, Last) William C. Morris	18. Mother's Name ((First, Middle, Maide Rulapaug	
	ss 1 and 2 sho of Health and I item 27 is me			ling Address (Street and Number or Rural Moffet Run Chesap	eake Beac	ch, MD 20732
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Reurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee	position (Name of emalory or other place) Veterans Cem 200 Sept	5 <u>Ch</u> Funeral H	
8760,	Medical Examiner bhysician and street buriar-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiac or		Approximate Interval Between Onset and Death Const and Death
.O. Box 687	death certif e attending id for use a	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	es ign ed	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
of Vital Records,	The taw ate has b page 2 st	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vit	f or Attanding Physician: 1 after death. Diractor: After this certifical I in by the funeral director, p	ertification; To Be	25. Was case referred to medical saxminer? 1 Yes 2 No	of 28c. Injury at 28 Work? M 1 Yes 2 No	e 5 Residence	ury occurred Living
	Hospital 4 hours Funeral ely filled	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the deal o	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the cause(d at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
)	To the I within 2: To the I complet	Me	29b. Signature and title of certifier	29c. License number 745	Ser	ate signed (Month, Day, Year)
	14		30 Name and address of person who completed cause of death (Item 23a) (Type	D LIUZ CANTE	2 WAG	DOLF, KID ZEGOZ
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 4 2005	Aparle		,

Amend#_19	.Per Informant		-	Certifica				Reg. No.	5 31	965	
Physician /Medical	Decedent's Name (First, Middenson Margaret Lo	lle, Last)						ber 15,2	Year 2005 6:	ime of Death	
Examiner	a Fecility Neme (If not institution 2107 Alice A	on, give street end number)				4b. City, Town, or Oxon H			of Death George	18	
Funeral Director	5. Social Security Number 578-54-2891	6. Sex 7. Ag	ge (In yrs. le 89	st birthday) If Und Month	er 1 Year Days		8. Date of Bi (Month, Da Septem	ay, Year) iber 8,19	9. Birthplace (5 Country) 16 Vir	State or Forei	
show of all	Usual Residence of Decedent 10a. State 10b. Count 10b. Prince	George's		Town or Location					10d. Ins	ide City Limit	
with the Mer n or 28a-f sl be notified Director	10e. Street end Number 2107 Alice A		OXC	10f. Z	ip Code 0745			•	10g. Citizen of Whet Country? U.S.A.		
be fled within 72 hours effer death with the Meryland the Hygiene. d other than "natural; or items 23s or 28s-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3. X. X. Widowed 4 □ Divorce	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐	•	. 13. Was Dec	edent of F ecify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Blac	e - American Ind k, White, etc.	ian,	
c 6 -	15. Decede	nt's Education est grade completed) College (1-4or	5+)	16e. Decedent's Us (Give kind of v life. DO NOT Home M		petion during most of wo d)	rking	16b. Kind of Bu			
and Mentel Hygiene. marked other than imatic event, the M To Be Comp	17. Father's Neme (First, Middle Richard Randa						me (First, Middle thershea	, Maiden Surnam			
100	19a. Informent's Name/Relation Theodore R. Gre			19h Mailing Addra 9670 Docs 9007 Doc	ss (Street Place	and Number or Rice P.O.Bo	ural Route Numb	oer, City or Town, aPlata C	Stete, Zip Code) H MD 20	646	
T T T T	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (20b. Pla	nce of Disposition (No metery, crematory of ropolitan	ame of other pla	сө)	Date		City or Town, St	ate	
Department of important: If any injury of pace.	21. Junature of Juneral Service	Voolel		10.15.45.45.45.4		ess of Facility (Sylvania		11 Funer uitland,		46	
hysician	23 Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause to only one cause on each I	d the death. ine.	Do not enter the m	ode of dyi	ng, such as cerdia	c or respiratory a	arrest,	Interv	oximate al Between t and Death	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Acut		cardial I		tion					
physician end s the buriel-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events	b. ————	Due to (or	as a consequence o	j):						
	Ceuse (Disease or injury that initieted events resulting in death) Last	d	Due to (or a	as a consequence of):						
d by the attending letached for use eletached fo	Pert II. Other significent condit	ions contributing to death b	out not result	ting in the underlying	ceuse gi	ven in Part I.		tobacco use cor			
b ed y								Yes 2 XNo	24b. Were aut	opsy finding	
9 2 G							perf	ormed?	of death?	on of cause	
certificate has the director, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 2 stractor, page 3 stractor, page 4 stractor, page 4 stractor, page 5 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 6 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 7 stractor, page 8 str	25. Was case referred to medic	al				26. Place of De	ath (Check only		1 🗆 Yes	2 LI NO	
	examiner? 1 ☐ Yes 2 ☐X No 27. Menner of Death 1x☐ Natural 5 ☐ Pend	28e. Date of Inju	ury 2	R/Outpetient 3 1 1 28b. Time of Injury	28c. Inju Wo			idence 6 Othe how injury occurr			
To the Troughts for Australing Triyatcian. The right within 24 hours after deeth. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	2 Accident inves 3 Suicide 6 Could	tigation d not be 28e. Plece of In	jury - At hon tc. (Specify)	M ne, farm, street, fact		Yes 2□No		(Street and Numb wn, Stete)	er or Rural Rout	e Number,	
thin 24 hours at the Funeral I ompletely filled		ing Physician: To the best I Examiner: On the basis of end manner s	of exemination							ause(s)	
within To the Comple				2	_	se number 5 2 2 8 9)	29d. Date signed	(Month, Day, Y	(ear)	
3)	30. Name and address of perso Nalin Mathur,	n who completed cause of	death (Item :								
State Hegistrar	31. Date filed (Month, Dey, Yea	r) 2. Regist	rer's Signatu			ino Xerio					

DHMH 16 Rev 6/95

			-		aryland / Dep			•	•	
			1 - For State Registrer		-	rtificate of			2005	31966
	Physici	an	1. Decedent's Name (First, Min	ddle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Gilbert		Tennings		rison	Septemb	er 11 2005	
	Examin	er	4a. Facility Name (If not institu)		or Location of Death		4c. County of Death	
	Funeval		5. Social Security Number	nal Hospital	ge (In yrs. last birthday	Laure	If Under 24 Hrs.	9 Date of Righ	Prince Geo	
	Funeral Director		578-44-9739	1 X M 2□F	73 Yrs.	Months Days		May 15,	1932 Wash	place (State or Foreign ntry) ington, DC
	pu 🛌		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or L	agatic a				
	Aaryla f sho	ō	MD How	,						10d. Inside City Limits 1 ☐ Yes 2XXNo
	28a-	Director	10e. Street and Number	aru	Savage	10f. Zip Code		100	. Citizen of What Cou	
	h with	al Di	9129 Windeme	re Way, P.O.	Box 237	2076	53		USA	•
	ems s	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	
36	s atte	y Fu	1 ☐ Never Married XX M 3 ☐ Widowed 4 ☐ Divord	larried 1 TXYes 2 □	1951 – 55	1 ☐ Yes XX No	Specify:	, , , , , ,	Specify: Wh	
8	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Madical Exertine must be rediffed at	Completed by Funeral		lent's Education		edent's Usual Occur	nation	16	b. Kind of Business/Ir	
215	hin 72	plet	(Specify only hig Elementary/Secondary (0-12	hest grade completed)	(Give	e kind of work done DO NOT use retire	during most of work	ing		audity.
2	ed wit rgiene rer the	Соп	12		Mecha	nic	·		Aircraft	
and	be fill ad oth	Be	17. Father's Name (First, Midd					e (First, Middle, Ma	iden Sumame)	
Maryland 21215-0036	hould d Mer marke matic	²	Ollie Harris 19a. Informant's Name/Relatio		19h Mail	ing Address (Street	1	Shreaves	City or Town, State, Zi	a Code)
<u>8</u>	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ODGs.		Helen L. Har							, MD 20763
ē,	s 1 au of Hea item		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla			c. Location - City or T	
Ē	Page nent c ant: If ury or		1 X Burial 2 ☐ Crematic 1 Donation 5 ☐ Other	n 3 □Removal from State (Specify)	'	l Vet. Cer	ı	-2005 C	rownsville	, MD
Baltimore,	permit. Departr Importe any inju		21. Signature of Funeral Servi	ce Liginae	2	2. Name and Addre	ess of Facility Funeral	Home, P.	A .	
_	405 8 8		77 7	Cp-		12 Ridge	ely Avenue	Annapo	lis, MD 21	
			23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final	ist only one cause on each l	a the death. Do not en ine.	iter the mode of dyli	ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	a. ALS						
R	Examiner				a consequence of):					
	n ÷	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
	ecuted and transi	Examiner	that initiated events resulting in death) Last	C						
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	cal E	Tosuming in account East	Due to (or as	a consequence of):					
687	ficate physis the			d	7-7-					
ŏ	leath certific attending pl	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	ery
m	deatle of for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			_lEctopic pregnance ☐ Other (specify)	<i>y</i>		Month	Day Year
P.O.	nat the de d by the a etached i	Physician/Med	9 Unknown							
S,	ires that signed t	by	Part II. Other significant cond	itions contributing to death i	out not resulting in the t	anderiying cause giv	en in Part I.		cco use contribute to t 2 ☐ No 3 ☐ Prot	ne cause of death?
Records,	w require been si should I	Completed						24a. Was an		
Re	Physicien: The lave this certificate has all director, page 2	dmc						autopsy performe	d? prior to co death?	psy findings available mpletion of cause of
a		0	25. Was case referred to med	cal			26. Place of Death	1 ☐ Yes 2 址 Check onlone	No 1 ☐ Yes	2LPNo
Division of Vital	Physicien: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		nt 3 DOA Oth			e 6 Other (Specif	y)
o u	- L		27. Manner of Death 1 ☑ Natural 5 ☐ Pen		ury 28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe how		
Sign	ten leal tor: the	cat	3 Suicide 6 □ Cou	stigation	iunz - At home form et		Yes 2 □ No	28f Location /Stree	at and Number or Rura	I Pouto Number
<u>></u>	in the second	Certification:	4 Homicide dete	ermined 286. Place of in building, e	jury - At home, farm, st tc. <i>(Specify)</i>	reet, lactory, office		City or Town, S		a noble (valiber,
	ospite hours unere ly fille		29a. Certifier 1 Certif	ying Physicien: To the best	of my knowledge, dea	th occurred at the tir	ne, date and place,	and due to the caus	e(s) and manner as s	lated.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical	Office)	el Exeminer: On the basis of and manner st	ated.			ed at the time, date	and place, and due to	the cause(s)
	With To	2	29b. Signature and title of car			, 29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
			30 Node and add	70100	400		10536	61 6	19 11	2005
			30. Name and address of pers Marcia B. Lo		19ath (Item 2 3a) (Type 232 Lakesi		Horsha	m, PA 19	9044	
	Sta		31. Date filed (Month, Day, Ye	ar) 32. Reist	rar's Signature					
	Registr	ar	SEP :	L 4 2005	wa K A	Just				

		State of Manuard / Denominary		-	_	
		1- State of Maryland / Depart State of Maryland / Depart Certif	tment of Health and ficate of Death		2005	31967
		Decedent's Name (First, Middle, Last)	dio or Beatin	2. Date of Dea	ath	3. Time of Death
Physicia /Medic		Jan Frederik Hulswit		Month 09	18 2005	1330 M
Examin			b. City, Town, or Location of De	eath	4c. County of Death	
	- 1	Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Berlin If Under 1 Year If Under 24 F	Irs. 8 Date of Birt	Worceste	
Funeral Director		227-46-5176 1XM 2 F 71 Yrs.	Months Days Hours M	lrs. 8. Date of Birt. (Month, Day Aug. 13	,1934 Vene	nplace (State or Foreign untry) ZUE]a
t pu x		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion			10d. Inside City Limits
Maryland	ŗ	MD Worcester Snow Hil				1 ☐ Yes ¾☐ No
6 4 (13/34) death with the Maryland ma 23a or 28a-f show	Funeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	untry?
A will will will will will will will wil	ralD	6027 Basket Switch Rd.	21863		USA	76
300 Ser de:	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	is Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		etc.
0036 nours after	ρ	3 Widowed 4 Divorced Year or Dates:	Yes 2 No Specify:		Specify: Whi	te
(176 175-0036 11215-0036 within 72 hours after and natural; or its than "natural; or its	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir	nt's Usual Occupation nd of work done during most of to NOT use retired)	working	16b. Kind of Business/li	ndustry
within within	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	gent		Insurance	Company
d d d d d d d d d d d d d d d d d d d	Be Co	17. Father's Name (First, Middle, Last)		Name (First, Middle,		Company
arylan should be not Mental is marked our umatic even	ToB	Marius Jan Frederik Hulswit	Margar	et Cather	ine de Heus	
2 sho and is m aum			Address (Street and Number or			. ,
G, N 1 and 1 tem 27 3ther tr		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition	Box 1097,	Date	11e, Pa. 18	
+ () らい シャー シェー シャー シャー シャー シャー シャー シャー シャー シャー シャー シャー シェー シャー シェー		1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Cape Henlo	1	19-2005	Frankford,	
alti.		21. Signature of Funeral Service Licensee 22. N	Name and Address of Facility	The Burba	ge Funeral I	
→ vo sessa			08 William St.			
		23a. Part 1. Enter the disease, or complications that caused the chart. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Colon Cancer Due to (or as a consequence of):	with metas	tatic ex	tension	
Examiner		Sequentially list conditions, b. Kidney failur	re			
pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events C. Liver Failure				
60, be execut ician and burial-tran	Examiner	resulting in death) Last c. Liver tailuve Due to (or as a consequence of):	<u> </u>			
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	calE	d				
r 68 ortifical		IF FEMALE:				
Box 68 eath certifica attending ph	lan/	23b. Was decedent pregnant in the past 12 months?	ctopic pregnancy		23d. Date of delive	very Day Year
P.O.	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ C	Other (specify)			,
	by Pl	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did to	bbacco use contribute to	the cause of death?
Division of Vital Records, for Attending Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be comed.				1 🗆 Y	′es 2□No 3□Pro	bably 4 Junknown
e 2 sh	Completed			24a. Was autop	sv prior to co	opsy findings available ompletion of cause of
Vital Re(lician: The lav certificate has		or Western Control		1 ☐ Yes		2 🗆 No
of Vita Physician: this certificanal director, rail	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Others	Death (Check only or	ne) lence 6 □Other (Speci	(6.1)
n of ng Physter this neral di	ın: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?		now injury occurred	
SiOI tendii leath. tor: Al	catic	2 Accident investigation	M 1 Yes 2 No			
Divi	Certification;	4 Homicide determined determined building, etc. (Specify)	t, factory, office	28f. Location (S City or Tow	Street and Number or Rur vn, State)	ral Route Number,
Division of Vital Rewithe Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investance and manner stated.	ecurred at the time, date and pla stigation, in my opinion, death or	ace, and due to the courred at the time, o	ause(s) and manner as a	stated. to the cause(s)
ro the vithin ?	29b. Signature and title of certifier 29c. License number 29d. Date s					
		Gy Stammer MD	D56312	5		
0 11		30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Pri	D56312 hway Drive Ber	1: 1:0		
C. H. 10	† 0	Gregory Stammus, MD 9733 Health 31. Date filed (Month, Day, Year) 32. Date filed (Month, Day, Year) 32. Date filed (Month, Day, Year)	nway Unive Ber	lin, MI).	21811	
Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2005 32. Figistrar's Signature	ente			

			1 - For State Unpend Item 2 1. Decedent's Name (First, Middle, Last)	State of Mary 3a&27 per i	land / Dep ne G848e	artmei <i>Miléa</i>	nt of H	ealth ar Peath		R	eg. No.	005	31968	
	Physici	an	James Eric Henderson							2. Date of Death Month Day Year 3. Time of Death				
N. P.	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							SEPTEMBER 18, 2005 6:13				
	Examir	er	116 N. PACA STREET APT 205 BALTIMORE CITY								40.	County of Dea	ıtn	
9	, Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Unde	er 1 Year	If Under 24	4 Hrs. 8	Date of Birth	1	9. Bit	thplace (State or Foreign	
2	Director		219 - 62-2426	M 2□F 48	Yrs.	Months	Days	Hours	Min. 1	Month Day	956	C	yland	
9	p ,		Usual Residence of Decedent 10a. State 10b. County	10	- C'- T		-		-					
	sho	ž	MD		c. City, Town or L Baltimor								10d. Inside City Limits M☐ Yes 2 ☐ No	
	28a-f	ect	10e. Street and Number		Darcinoi		in Code				0- 02	(1)		
	with with	ā	116 North Page Charact #205							zen of What Ci JSA	ountry?			
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.			21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						4. Race - Am	erican Indian	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eristical national Existing at 2008.	by	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puèric 1 ☐ Yes ※ No Specify:			Puerto Rica	an, etc.)		Black, White, etc. Specify: Black		
2-0	72 ho natur	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of					16b.			Kind of Business/Industry			
2121	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	nd of work done during most of working DNOT use retired)							
	ygier ygier tt.	Co	12th		Tr	ruck	Drive				Private			
Maryland	ntal H od otl	Ве	17. Father's Name (First, Middle, Last)	Tr					s Name <i>(Fi</i> lma Ke		Maiden .	iden Sumame)		
Ž	d Mey mark	Ţ	John H Henderson 19a. Informant's Name/Relationship (Tvi		10h Madi	Add	· Ctront				0.	Town, State,		
<u>⊠</u>	ith an		Joseph T. Riley -	. ,	4729	Midw	ood A	venue;	; Balt	timore	MI	2121	_	
	tam Hea tam		20a. Method of Disposition	2	0b. Place of Dispo	osition (Na	ame of		Date		•	ation - City or	Town, State	
e E	Pages ent of nt: # i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Riverdal			·	9/24/2	24/2005 Riverdale, Maryland				
Baltimore,	permit. Departminimportal	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services												
1			23a. Part Denter the disease, or comple	cations that caused the								11G 20	Approximate	
	Physician /Medical Examiner		shock, or heart failure. List only take cause on each line.									Onset and Death		
1 K	ate be executed hysicien and he burial-transit	Physician/Medical Examiner	Examin	Sequentially list conditions. Say Lee ling to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co									
О. Вох	death certif e attending d for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s			- 144		2	3d. Date of de Month	livery Day Year	
rds, P	w requires that the been signed by the should be detache	ρ	Part II. Other significant conditions con	tnbuting to death but no	ot resulting in the u	ınderiying	cause give	n in Part I.			oacco us		the cause of death?	
Il Records,	The law ete has b pege 2 st	Completed								24a. Was ar autops perform	y	24b. Were at prior to death?	utopsy lindings available completion of cause of	
of Vital	Physician: Th this certificate ral director, peg	Be	25. Was case referred to medical examiner? 26. Place of Death Check only one											
of	Physic this c	۵,	NTV1es 5 □ 140		2 ER/Outpatier			4 11 110151	ing Home	5 Reside	ence 6	Other (Spe	city) SCENE	
Division o	Sing After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				28c. Injury at Work? M 1 Yes 2 No			28d. Describe how injury occurred				
Divi	i Dig		4 Homicide determined 286. Place of Injury - At nome, Tarm, Street, factory, office building, etc. (Specify)					281. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospital	Medical	(Chack Only Z Medical Casillin	ician: To the best of my	y knowledge, deat mination and/or in	h occurred	at the tim	e, date and p	place, and occurred a	due to the ca	ause(s) a	and manner as	s stated.	
	thin 2	Med	29b. Signature and title of certifier	and manner stated.										
	Veiti To Cor	29b. Signature and title of certifier 29c. License number O C M E 29d. Date signed (Month, Day, O C M E)												
R			30. Name and address of person who co	npleted cause of death	(Item 23a) (Type,		PENN 9	TREET	' RAT	TTMODE	 т. 1мг	Δργτ.Λιπ), 21201	
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's	Chile	I	TTIATA P	ال تالىدىدىد	ى مى المى المى المى المى المى المى المى	TTION	LT 6	7777777	, 21401	
	Registi		SEP 2 8 2005	Fee	K R	100								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	aryland / L	Certifica Certifica		Death		2.00	5 31	969	
	Physici	an	1. Decedent's Name (First, Middle, La	-	** 1.				2. Dete of Deeth Month Septemb	Dey	3. T	Time of Death	
	/Media	al	Katie Ann 4a Fecility Neme (If not institution, giv	nabelle	Henlir	1e		4b. City, Town, or Lo		er 21,		:20 AM	
	Examir	ier	Oakland Nursing a		itation	n Cente		0akland		Garret			
	Funeral Director		5. Social Security Number 236-42-0237 Usuel Residence of Decedent	Sex 7. Ago I□M 2ਊF	95	Yrs. If Und Month	der 1 Year ns Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 9,	Year) 1910	9. Birthplace (Country) West V	Stete or Foreign	
	/lend	Ì	10e. State 10b. County		10c. City, Tow	n or Location					10d. In:	side City Limits	
	a Mary	हु	MD Gar	rett			Oa	akland			1[☐ Yes 2 ∏ No	
	vith th	Dire	10e. Street end Number			10f.	Zip Code		10	g. Citizen of W			
	ne 234	Funeral Director	8475 George Wash	ington Hig		13. Was De	cedent of h	21550	ecify Yes or No-		USA - American Ind	dian.	
9500-61212	be filed within 72 hours efter deeth with the Marylend titel Hygiene. od other then "naturel", or items 23a or 28e-f show event, the Medical Examinar must be notified at	by Fun	1 Never Merried 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:				dispenic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black	k, White, etc. : White	,	
2	72 hc natur	Be Completed by	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16e.	Decedent's U	sual Occup work done	oation during most of work d)	ing	6b. Kind of Bu	siness/Industry		
7	within ene. than	dmc	Elementary/Secondary (0-12) 9th	College (1-4or 5	+)		House			ī	Home		
	i Hygi other	Ö	17. Father's Neme (First, Middle, Last))			nouse	18. Mother's Name	e (First, Middle, N		Home mame)		
yland	should be nd Mantel marked o	10	Marcellus		Arnol	d		Martha		W	otring		
Mar	0 0 5		19a. Informant's Name/Relationship (_		and Number or Run			State, Zip Code,)	
	1 and Health em 27		Joretta G. Kuhn, 20a. Method of Disposition	daugnter	20b. Place 0	f Disposition (*	Vame of	Gormania,			City or Town, St	tate	
Ē	Pages nant of int: if Its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			ry, crematory c e c.a. Cre		Į.	1/22/05 N	forcant	own WV		
saltimore,	permit. Pages Department of important: if it any injury or o	Ì	4 Donation 5 Other (Specify) Omega Crematory 9/22/05 Morgantown 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 32 S. Seco										
n	89589		Bladle, H.	Md. 21	.550								
	Physician		23a. Part1. Enter the disease, br com shock, or heart failure. List only	plications that caused one cause on each lin	the deeth. Do	not enter the m	node of dyir	ng, such as cardiac	or respiratory arre	st,	Appro Interv Onse	oximate val Between et end Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	renal fa	ailure						6 mc	onths	
		Jer		congest	Due to (or as a Lve hear						1 ye	ear	
	cuted	amlr	Sequentially list conditions,	b	Due to (or as e	consequenca o	of):				1		
60,	icate be executed physicien and s the burial-transit	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	atheroso	clerotio	c cardi	ovasc	ular dise	ase		5 ye	ears	
68/60,	tificate ig physias the	Aedical Examiner	that initiated events resulting in death) Last		Due to (or es e	consequence o	of):				1		
X Q Q	th cert tandin r use	and		d							1		
	the att	/sici	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	n the underlying	g cause giv	en in Part 1.	23b. Dld tol	pacco use con	tribute to the c	ause of death?	
т. О	es that tha death cer igned by the attandin be detached for use	y Ph	atrial fibrillati	lon					1 □ Ye	s 2⊡No	3 Probably	4 🗌 Unknown	
Hecords,	requir	Completed by Physician/					***		24a. Wes er perform	autopsy led?	24b. Were au available completio	topsy findings prior to on of cause ?	
	The ate h page	Com							1 □ Ye	s 2X No	1 🗆 Yes	2□ No	
VITa I	Iclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			DO Oth	26. Place of Deat					
Ö	Attending Physician: ir death. ector: After this certific by the funerel director,	۳. T	1 ☐ Yes 2 ☐ No 27. Menner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, De)	nt 2□ ER/Ou y 28b.	Time of	28c. Injui	4LTNursing Ho	me 5 Reside				
<u> </u>	anding ath. rr: Afte	atlo	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	n	(Year)	Injury M		rk? Yes 2 □ No					
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At home, fa c. (Specify)	arm, street, fact	tory, office		28f. Location (Str City or Town		∍r or Rural Rout	e Number,	
_	To the Hospital or within 24 hours after To the Funeral Directory completaly filled in	Ce	29a. Certifier 1 Certifying Ph	nysician: To the best of	of my knowledge	a deeth occurre	ed et the tir	me, data and place.	end due to the ca	use(s) and mar	nner as stated		
	n 24 h	Medical	(Check only 2 Medical Exam	niner: On the besis of end manner ste	examinetion en	d/or investigati	ion, in my o	ppinion, death occurr	ed et the time, da	te and place, a	nd due to the c	ause(s)	
	with To th	Σ	29b. Signature end title of certifier	11-		1100	29c. Licens			_	(Month, Day, Y		
			-wew-	Mann		MP.	D002	7/37	5	ebrempe	er 21, 2		
			30. Name end address of person who Walter K. Naumanr				ident	MD 21520					
	Sta Registr			A. Carrier	er's Signeture	Agree	& D						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20051 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 08:45 AM Naomi Marie Humbertson 15 2005 Deptember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. iast birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F July 26, 1958 Virginia Director 218-70-1529 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Grantsville by Funeral Director MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21536 44 Railroad St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "neturel", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing ll th Packer Item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Marie Dodson Ernest Broadwater ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 104 Morris Ave., Friendsville, MD 21531 Lucy Marie Broadwater/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If eny injury or once. Country Side Crem. Sept 19, 2005 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) Newman Funeral Homes, P.A., PO Box 275 Clomace 179 Miller St., Grantsville, MD 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seps1 -2 DAYS **Physician** /Medical Due to (or as a consequence of): Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Examiner Due to (or as a consequent attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown signed be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 X No 2□ No | □ Yes 1 Tyes 25. Was case referred to medical examiner? director. 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 NInpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1190 HAGENSTOWN METWA KOMO MI MU alto 110 20052. Registrar's Signature 31. Date filed (Month, DSE)

DHMH 17 Rev 1/200

State Registrar

19

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept **Physician** 12^{Pay}2005^{ear} 1840 Irma Lorene Humphreys /Medical 4b. City, Town, or Location of Death Annapolis 4a. Facility Name (If not institution, give street and number) 4c. County of Death Anne Arundel Examiner Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, June 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1915 1 M 2 TF 90 214-52-6365 June Maryland Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other traumetic avant, the Medical Examiner and be notified at Maryland Anne Arundel Riva 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 2860 Hambleton Road 10g. Citizen of What Country? United States with ō Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced o Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker own home 17. Father's Name (First, Middle, Last)
Cleveland Benjamin Grover 18. Mother's Name (First, Middle, Maiden Surname) Audrey Thomas Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If itam 27 Is any injury or other trainonce. Lorene Bowen-duaghter 2860 Hambleton Rd. Riva MD 21140 St. Paul UM Cemetery Page 16 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lusby Maryland *4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. rd. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ONGO disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 4 Anknown 1 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 🗌 Yes 2500 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔽 🚾 1 patient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of D ath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) yd ni 4 Homicide a Funeral [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To tha within 2 29b. Signature trile of certific 29c. License number 29d. Date signed, (Month, Day, Year) 2005 who completed cause of death (Item 23a) (Type Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 205 31972 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2005 Sept. 4, 12:47A M (an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1821 Graybird Court Severn Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Mar. | 29, 1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F 217-28-1891 98 Maryland Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, fnside City Limits in than "natural", or Items 23a or 28a-f show the Medical Exactives must be notified at Anne Director Maryland 1 ☐ Yes 2 No Arunde1 Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 Graybird Court 21144 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo 9 Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any injury or other treumatic event, tha Me any injury or other treumatic event, tha Me any singes. Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Contee Wesley Madora Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Gaither/Daughter 6664 Roberts Court #92 Glen Burnie, MD21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Moses Cemetery 9/8/2005 Lothian, MD 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 21. Signature of Funeral Service Licensee Glady a. sevel1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** larc 140C /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month 4 Pregnant at time of death signed by the all 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1□ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one) Hospital: Other: 4 Nursing Home 1 Yes 2 No ۵ 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) 3 DOA this Director: After this in by the funeral of 28a. Date of fnjury (Month, Day Year) 28b. Time of 27. Manner of Teath 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36246 levueluo 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Glen Burnie MD) laine 165 Roesler Koberl 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 4 2005 Registrar Souls

State of Maryland / Department of Health and Mental Hygie $\Re \left(\right) \left(\right) 5$ 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Martin Clinton Hughes Sept 10 2005 4:50A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 8419 Mt. Harmony Lane Calvert Owings If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Yrs. Director 84 1920 228–16–5478 30, Virginia Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic evant, it a Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Calvert Owings MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8419 Mt. Harmony Lane 20736 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If Itam 27 Is marked othar than "netural", or Ita 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: by lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 maintenance engineer residential apartments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hughes Louise Headley James Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20736 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Itam 27 Is any injury or other trau Mrs. Roberta Hughes, wife 8419 Mt. Harmony Ln., P.O. Box 1144, Owings, MD 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 NOther (Specify entombment Ft. Lincoln Mausoleum 9-14-2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nos tate **Physician** disease or condition resulting in death) 218 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Dualto (or as a consequence of) Examine g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical d attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cegifie D16823 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Robert Schlager, M.D., 110 Hospital Rd., Suite 111, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) State Bergue & Spark SEP 1 3 2005 Registrar

DHMH 17 Rev 1/200

			For State Registrar	State of Maryla		artment <i>rtificate</i>				giene 0 (15	31974
	ģ.		Decedent's Name (First, Middle, Las	t)					2. Date of De	ath	Vaar	3. Time of Death
	Physici /Medic	_	Ruth Violet Han							11, 2005		8:30 A M
	Examin	er	4a. Facility Name (If not institution, give Calvert Memorial)			_		cation of Deat		4c. County		
			5. Social Security Number 6. Se		s. last birthday)	If Under 1		rederic	O Data of Pie	eb.		County
П	Funeral Director			□M 2XF 91	Yrs.	Months	Days H	Hours Min.	Nov • 1	8, 1913	Per	place (State or Foreign ntry) nsylvania
	ը .		Usual Residence of Decedent	100	VI. 7							
	ehov	5	10a. State 10b. County	_	City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 XNo
	28a-f	ect	MD Calvert 10e. Street and Number	County	Dunkirk	10f, Zip C	Code			10g. Citizen of V	/hat Cou	
	3a or		11605 Jester Way			207				U.S.A		
	within 72 hours after death with the Maryland ane. then "neturel", or items 23s or 28s-f ehow the Madicel Exeminar must be notilised at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decede	ent of Hispa	anic Origin? (S Mexican, Puer	pecify Yes or No)- 14. Raci	- Ameri	can Indian,
36	or its	y Fu	1 Never Married 2 Married	1 ∐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2		Specify:	o riican, etc.)	Specify	k, White, : Wh	ite
21215-0036	hours turel'	ed by	3X Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:								
5	in 72	Completed	(Specify only highest gra	de completed)	(Give	dent's Usual kind of work DO NOT use	done durir	ing most of wo	rking	16b. Kind of Bu	siness/ir	naustry
212	d with	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	emaker	c			Home	:	
nd	al Hy d oth	Be	17. Father's Name (First, Middle, Last)				18	B. Mother's Nar	ne (First, Middle	, Maiden Sumam	Θ)	
yla	Meni Meni Marke Marke	ဥ	George Switzer						eth Tra			
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (7							er, City or Town,		
ō,	1 and Healt Iem 2	1	Nancy L. Williams 20a. Method of Disposition		Place of Dispo	sition (Name	e of		Date 14,	aryland 20c. Location -		
<u>o</u> E	ages ant of ht: if it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ri	verdale							oro, Marylan
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23s or 28s-f show simportant: if item 27 is marked other than "naturel; or items 23s or 28s-f show appringnty or other traumatic event, the Madical Examinar must be notified at Once.	Ì	21. Signature of Fundamental Con									ert, P.A.
m	Depa impo eny is		Michael W. I		8	125 Sc	outher	rn Mary	land Bl	vd. Owi	ngs.	MD 20736
			23a. Part1. Enter the disease, of comp shock, or heart failure. List only	olications that caused the de one cause on each line.	ath. Do not en	ter the mode	of dying, s	such as cardia	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a ACUTE	RENAC	_ F/	FILLU	LRE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
	to.	e_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of):							
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events								-	
o,	an an		resulting in death) Last	Due to (or as a conse	equence of):							
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dlcal	•	d								
9	isath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy							
Вох	atten atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fe	tal death 3	Ectopic pred				23d. Dat Moi	e of deliv	ery Day Year
o.	that the di ed by the detached	hys	9 ☐ Unknown	9□ Unknown								
S, D	The law requires that ste has been signed b page 2 should be deta	ру Р	Part II. Other significant conditions of		esulting in the u	inderlying cat	use given ir	n Part I.	23e. Did t	obacco use contr	bute to t	he cause of death?
ord	w require been si should t	ted	NUPERSENSI	DN					1 🗆 1	Yes 2 No	3 Pro	babły 4 ∏Unknown
Vital Records,	e law r has be je 2 sh	Completed							24a. Was	psy p	rior to co	opsy findings available ompletion of cause of
al H											leath?	2 🗆 No
Z.	Physician: 7 this certificeral director, p	Be	25. Was case referred to medical examiner?	Hospital:					ath (Check only o			
Division of	Phys r this eral di	1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	☐ ER/Outpaties 28b. Time o		c. Injury at Work?	4 Nursing H		dence 6 Other		fy)
ion	Attending r death. sctor: After	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м		2 □No				
ivis	ter death frector: by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory,	office		28f. Location (City or To	Street and Numb	er or Rur	al Route Number,
	urs afte											
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my k	nowledge, deat nation and/or in	h occurred at vestigation, i	t the time, o	date and place ion, death occu	e, and due to the arred at the time,	cause(s) and ma date and place, a	nner as s and due t	stated. o the cause(s)
	within 7	Mec	29b. Signature and title of certifier	and manner stated.		29c.	License nu	umber		29d. Date signed	(Month,	Day, Year)
	- 3 - Ö		PILLA	Mu M	۵	D	403	370		9/12		
	0		30. Name and address of person who	completed cause of death (It	em 23a) (Type,					-//		
	3		Peter L. Wisniew	ski, M.D. 110	Hospit	al Roa	ad, St	uite 31	O, Prin	ce Frede	rick	, 20678
À.	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 3 2005	32. Registrar's Sig	nature	,						
	A TOTAL TOTAL CONTRACTOR	N. 17		The state of the state of	Carlotte Contraction of the last							

State of Maryland / Department of Health and Mental Hygierie U U 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Sarah Hanshaw Sept. 6, 2005 7:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9911 Stonewood Court Prince George's To Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

8. Date of Birth
(Month)

8. Date of Birth
(Month)

9. Birthplace (State
Country)

Mary I and

North Source
Min. Aug. 27, 1938 Upper Marlboro 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 214-34-6993 Director Usual Residence of Decedent filed within 72 hours effer death with the Maryland Hygiene. other than "natural", or items 23a or 28e-f ehow 10b. County Prince 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygeler. Importent: if Itam 23 is marked other than "natural", or items 23a or 28e-1 ehov any injury or other tremultic event, Ita Marylaid at Maryland Upper Marlboro 1 Yes 2 No George's Direct 10f. Zip Code 20772 10e. Street and Number 9911 Stonewood Court 10g. Citizen of What Country? USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ▼No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Green Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) New York City Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Giles Cook, Sr. E11a Mae Gross 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Reynolds/Daughter 1605 Grays Road Port Republic, MD 20676 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State
1 1 □ Donation 5 □ Other (Specify) So. Mem. Gardens 9/13/05Dunkirk, MD 21. Signature of Funeral Service Licensee Sewell Funeral Home 22. Name and Address of Facility 1451 Dares Beach Rd. Prince Frederick, MD Blady a. Secret 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and death)

Metastatic Colon Concerticular death) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) been signed by is should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. certificate 1 Yes 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EN/Outpatient 3 DOA 1 Yes 2 No Certification: To To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 33109 SEPTEMBER 8, 2005 30. Name and address of son who complete cause of death (Item 23a) (Type, Print) Hwang, M.D 3800 Reservoir Rd. NW Washington, D.C. 20007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2 2005

Hanshaw

Sarah

32. Registrar's Signature

			1- State of Marylar Registrar Amend Item 23a per Dr., C	nd / Depa 3848 - 10	artment of Health and 103/05 dhb thicate of Death	Mental Hygier	2005 31976
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medic		Hugh Watson Hopkins			Sept.16	,2005 10:17p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death
			Union Hospital		E1kton		Ceci1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		219–36–5563	Yrs.		June 19	,1940 MD
	land I			ity, Town or Lo	cation		10d. Inside City Limits
	Mary 1 sh	ğ	MD Cecil	E1kt	ton		1 Yes 2 □ No
	r 286	Director	10e. Street and Number	DIK	10f. Zip Code	10g.	Citizen of What Country?
	h with		259 E. Main St., Apt. 3		21921		U.S.A.
	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Acal Examir at must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
9	or Ite	/Fu	1 Never Married 2 Married 1 X es 2 No	1	1 Ses 2 No Specify:	no Alcan, etc.)	Black, White, etc.
90	urel',	d by	Year or Dates: 196	2			Specify: White
7	2 8 8	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16b.	. Kind of Business/Industry
42	within and the series of the s	щ	Elementary/Secondary (0-12) College (1-4or 5+)				Dotail
9	Hyg ant,		17. Father's Name (First, Middle, Last)	_ Cas	shier 18. Mother's Na	me (First, Middle, Maid	Retail (en Surmame)
lan	© 5 5 €	To Be	Granville William Hopkins				
Maryland 21215-0036	d 2 should be and Menta 7 is marked treumetic e	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or R	yn Watsor Jural Route Number, Cit	
	1 and 2 Health a :em 27 is		Yong Lee/Friend	42 St	ringbrook Lan	e. Newark	C.DE 19711
J.	ss 1 and of Healt item 2			Place of Dispos	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State
Ĕ	Pages nent of I ant: If it ury or o		I bunal 2 Scremation 3 Hemoval from State _	-	erris. Incl ^{Sep}	ot. 22,	est Chester, PA
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Furieral Service Licensee		. Name and Address of Facility	.003	
	207 2 2		ATHE		Andrew G. Gee 259 E. Main St		
	- 78		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ente			Interval Between
	Physician		Immediate Cause (Final disease or condition	1.0	Aspiration -	Agona1	Onset and Death
	/Medical Examiner		resulting in death) Due to (of as a consec	quence of):			1
		7	Sequentially list conditions, b. Lue to to a a consecution and the sequence of	o (e	- Cardia	e urre	est
	ted nsit	nine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	L . 1	11.	to a	
,	execun n and al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consec	quence of):	Just 1725	1 March	3
8760,	cate be executed physician and the burial-transit	dical	a 5/A E	xten	istre ent	eroly si	7 5
9	요문	•					
Вох	death certific e attending p d for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy		23d. Date of delivery
	0 0	Physician/M	1 Yes 2 No 4 Pregnant at time of c		Other (specify)		Month Day Year
P.0	The law requires that the de site has been signed by the a bage 2 should be detached i	Phy	5 CONCIONIT				
ŝ	ires this signed I be de	by	Part II. Other significant conditions contributing to death but not res	sulting in the un	nderlying cause given in Part I.		o use contribute to the cause of death?
orc	w requir been si should	eted	D D Colores as t	1519		1 🗆 Yes	2 No 3 Probably 4 Unknown
Vital Records,	elaw hast je 2 s	Completed	Incumonta, Atri	L	ibrillation	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
aF			Intertion Cardio	2700	athy	performed?	
ξ	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:		Other	ath (Check only one)	
of		1. To	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient 2 ☐ 27. Manny of Death 28a. Date of Injury	ER/Outpatient 28b. Time of	t 3 DOA 4 Nursing I	dome 5 Residence 28d. Describe how in	
on	ding Phi th. After thi funeral	tion	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐ No	Edd. Bosonso now in	jury occurred
Division	Attending r death. sctor: After	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At h	ome, farm, stre	eet, factory, office		and Number or Rural Route Number,
ā	el or s afte ol Dire	Certification:	4 Homicide determined building, etc. (Special	(y)		City or Town, Sta	ate)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known and manner stated.	owledge, death ation and/or inv	occurred at the time, date and place restigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. C	Date signed (Month, Day, Year)
			Hier Q. My us		D00 572	10 9	121/05
			30. Name and address of person who completed cause of death (Iter	n 23a) (Type, I	Print)		121100
_			Item Nyman III	- W	. High st	rect Si	rite 203
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signa				
	Registr		OCT 0 3 2005	home	W. Comments		
DH	MH 17 Rev 1/20	1131		F 14			

ORIGINAL.

State of Maryland / Department of Health and Mental Hygien 2005 31977 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 25, 2005 **Physician** Thomas Henry 9:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner College View Center Frederick Frederick 8. Date of Birth Aug. Ye. 7. Age (In yrs. last birthday) 91 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign County) Mary Land 5. Social Security Number **Funeral** Days Hours Min 222-05-0576 1 X M 2 □ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits in then "natural", or Items 23a or 28e-f ehow The Medical Examiner must be notified at Maryland Prince George XX Yes 2 □ No Bowie Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8700 Normal School Road 20719 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XD Yes 2 ☐ 12041-1945 If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3X Widowed 4 □ Divorced eted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "nat any injury or other treumatic event, the Madic once. College (1-4or 5+) Elementary/Secondary (0-12) Intelligence Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles T. Henry Florence Colbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles G. Poindexter, Sr., nephew 188 West All Saints St., Frederick, MD 21701 20b. Place of Disposition (Name of 20a. Method of Disposition

f □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Lakemont Memorial Gardens Sept. 30, 200 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician MULTI INFARCT DEMENTIA 4 & AM /Medical Due to (or as a consequence of) Examiner efrebro vashim YEAR) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner g physician and as the burial-transit certificate be executed C. 10 48 An) Due to (or as a consequence of) Box 68760, Physician/Medical d ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 2 No 1 Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After tnjury 1 Natural 5 Pending death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of tntury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) September 26, 2005 7-31912 500 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 2 mp 21702 MENO(91, ND-1564 4 mossum rown Pine, FREDERICH Juni 2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 3 2005 State Par inco Registrar

			1 - For Stata Registrar	State of	Marylan	d / Depa	artment rtificate	of H	ealth a Death	and M	ental Hy	giene Reg. No.		31978	3
	Q	40	Decedent's Name (First, Middle, Last,)							2. Date of De	ath		3. Time of Death	·
	Physici /Medi		James	Lee	Hinm	an, Sr					Month	Day her	6, 200		М
)	Examir		4a. Facility Name (If not institution, give			iciny Di		Town, or	Location of	of Death	Бересп		County of De		_
			30124 Peggy Lane				Pri	nces	s An	ne		S	omerse	t	
	Funeral		5. Social Security Number 6. Şe:		. Age (In yrs.	last birthday)		1 Year	If Under Hours		8. Date of Bir (Month, Da			irthplace (State or Forei	ign
	Director		215-14-3596	M 2□F	83	Yrs.	WOITIS	Days	Houis	IVIII.	10/15/			rvland	
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or Lo	eation							Land Lands Countries	
	eho	5	Tou. State		100. 01.	y, 10mil 01 Ec	Cation							10d. Inside City Limit	
	the N	ect	MD Somerset	<u>. </u>	P	rinces	S Ann					40. 000			
	a or	D.					TOI. ZIP		0.50			iug. Citi	izen of What C	ountry?	
	eath	eral	30124 Peggy Lane	12. Was Deced	ent Ever in II	S 13	Was Deced		.853	ain? (Sne	oitu Vac or No		USA 14. Race - Arr	agican Indian	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23e or 28e-f ehow ther, the Medical Exacilier must be notified at	Funeral Director	1 Never Married 2 Married	Amed Ford	es?	.3.	If Yes, spec	rfy Cubar	n, Mexicar	i, Puerto F	cify Yes or No Rican, etc.)	,-	Btack, Wh		
336	urs at	þ	3 Widowed 4 □ Divorced	Iff Che Give	es: WWII		1□Yes 2	No	Specify:				Specify:	That to	
21215-0036	2 hou	ted	15. Decedent's Edu	cation	MMII	16a. Dece	dent's Usua	l Occupa	ition			16b. Ki	nd of Busines	Whites/Industry	
215	hin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1	lor 5+\	(Give	kind of wor DO NOT us	k done d e retired,	luring mosi)	t of workir	ng			,	
21	d with	Completed	12	2		Mort	ician					Fu	neral	Industry	
	al Hy othe	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle			21132521	
/lai	uld b Menti	TO E	Lee Arthur Hinman						Fann	ie La	wson				
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natur any njury or other freumatic event, Ita Medical 9008.		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City o	r Town, State,	Zip Code)	
	and 2 allth n 27 l		James L. Hinman, J	Jr./Son		11673	Some	rset	Ave	., Pr	incess	Ann	e, MD	21853	
Baltimore,	of He fiten roth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	Romoval from C		Place of Dispo emetery, crer	sition (Nam	e of			ate		cation - City o		
Ĕ	permit. Pages Department of I Importent: If ite any injury or of		`4 □Donation 5 □ Other (Specify)			echwoo	nd Cem	eter	v 0	9/10/	/2005	Prin	CASS A	nne, MD	
alt	Departr Mport any inj	_	21. Signature of Funeral Service Licens	be V	2	из	Name and	Addres	s of Facilit	Home	2002		icess_A		
m	205 5 5		MNUSTANIA	naw	4 M0029	5 Pr	inces	s Ar	ne.	Marv1	land 21	853			
		/	23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interpretation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.									rrest,		Approximate Interval Between	
	Physician	(mmediate Cause (Final disease or condition											Onset and Death	
	/Medical		resulting in death)	Due to (o	r as a conseq	uence of):		,)					
	Examiner		Sequentially list conditions	Coro	nany	Av	ferry	17/3	ease						
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conse	uence of):	J								
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
Ő,	e exe	ũ	resulting in death) Last	Due to (o	r as a conseq	uence of):									
8760,	cate be ex physician the buria	dical		d											
9		Med	IF FEMALE:												
Вох	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 Feta	Ideath 3	Ectopic pre					2	23d. Date of de Month	elivery Day Year	
0.	the a	/sic	1 Yes 2 No	4□Pregna 9□Unknov	nt at time of d vn	eath 5□	Other (spe	ecify)					WOTH	Day 16a	
<u>a</u> .	that the deatt ed by the atte detached for	Ph	Part II. Other significant conditions con	ntributing to dec	ath but not ros	ulting in the u	adarh ina aa		o in Don I		220 Dide	abaaaa	an contribute	to the cause of death?	
S	signed to	by	Ausina Ro	c fee	C C C C C C C C C C C C C C C C C C C	unting in the u	nderlying ca	iuse give	mmranti.					Probably 4 Unknow	
oro	w requir been si should	stec	Acrtic Stenosis 24a. Was an autopsy performed? die die stenosis 15 Yes 2 No 3 24b. Was an autopsy performed? die die stenosis 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1 N									- Unknow			
Records,	e law has t	nple	- 1,7								24a. Was autor	osy	prior to	utopsy findings availab completion of cause of	le f
E		Cor	ltypertens	ica							1 ☐ Yes	200 No	death? 1 ☐ Ye	s 2 No	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	1						of Death	(Check only o	опе)			
of	d is	P	1 162 20 140			ER/Outpatien			4 🗆 190	rsing Hom			3 □Other (Sp	ecify)	
n o	gu (tei	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month	Day Year)	28b. Time of Injury		Bc. Injury Work			8d. Describe I	how injur	y occurred		
Sic	Attending r death. ector: Alter by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				М		'es 2 □ l						
Division	l or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	28e. Ptace of building	if Injury - At ho g, etc. (Specify	ome, farm, str y)	eet, factory,	office		2	8f. Location (3 City or To	Street and wn, State,	d Number or F)	Rural Route Number,	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		CO. Continue of Continue Characteristics	-1-1											
	Hos 24 ho Fun Fun tely f	edical	29a. Certifier Certifying Phy (Check only one) 2 Medicel Exami	ner: On the bas	is of examina	wiedge, death tion and/or in	n occurred a vestigation,	it the tim in my op	e, date an inion, deal	d place, a th occurre	nd due to the id at the time.	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	ir stated.			License							
	Z Z Z S		Man 0	Lysic	C				129	1 6	lan	~ C	1001	th, Day, Year)	
			SNO	73 7/0			1	13	16-1	()	עריי		1001	<i>U</i> 3	
			30. Name and address of person who con Jon when C. Potrer 31. Date filed (Month, Day, Year)	Dimpieted cause	or death (Item	1 23a) (Type,	+ Ban	Down	e Sui	te 10	1 Seli	Shu	y mo	21804	
• .	Sta	ate	31. Date filed (Month, Day, Year) SFP 1 4		gi frar's Signa	ture					'	-	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2005

For	State of Maryland / Department of Health and
Stata Registrar	Certificate of Death

31979

			Registrar			ertificate of	Death	R	lag. No.			
	Physici /Medic		Decedent's Name (First, Middle, Last)	Thoma	as Ha	ley		2. Date of Dea Month Septembe	er 24, 200	3. Time of Death 1935 P M		
	Examin		4a. Facility Name (If not institution, give s 296 Molitor Road			4b. City, Town, o	or Location of Death n		4c. County of			
	Funeral Director		210-30-0627	7. Age ('In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 6,	1933 S	Birthplace (State or Foreign Country) Maryland		
	/land low		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or	Location				10d. Inside City Limits		
	Be-fst	ctor	Maryland Cecil		Elkton					1 ☐ Yes 2 X No		
	with th	Dire	10e. Street and Number			10f. Zip Code		1	log. Citizen of Wh	•		
	s 23	erai	296 Molitor Road	12. Was Decedent Ev	erin II S 15	21921	dispania Origin? (Sr	acifu Vac or No.		States American Indian,		
9	within 72 hours after death with the Maryland ene. than "naturai", or items 23a or 28e-f show ta Madical Exait and intelled all	Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces? 1 MYes 2 No	1953-	I. Was Decedent of H If Yes, specify Cub		Rican, etc.)	Black,	White, etc.		
93	irai',	d by	3 Widowed 4 Divorced	Year or Dates:	1980	TES ZUALNO	Зреспу:		Specify:	White		
15-("natu	lete	15. Decedent's Edu (Specify only highest grade		16a. Dec	edent's Usual Occup re kind of work done . DO NOT use retire	pation during most of work	king	16b. Kind of Busin	ness/industry		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other treumatic event. I've Medical Exaits are must be colified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ef Warran	t Officer			tates Army		
nd	be file	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)			
2	should be nd Mental marked o	T _o	Thomas Haley 19a. Informant's Name/Relationship (Ty	no Print)	10h Ma	iling Address (Street	Inez Wy		City or Town St	ata Zin Cada)		
Ma	d 2 sho th and ?7 is mu treum		Mary Lou Haley/Wi	•		Molitor 1						
	t Health Hem 27 trem 27		20a. Method of Disposition	10		position (Name of rematory or other pla		Date	20c. Location - Ci			
E	Pages nent of int: if it iry or o		1 XBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	lemoval from State		Cemetery	Oppo	ember 2005	Galena,	Marvland		
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service License	99		2. Name and Address of Facility.						
0	# # # # #		Donned &	3. Hube		03 W. Sto	ckton St.	, Elktor	1, MD 21	.921		
П			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the ne cause on each line	ne death. Do not e ·	nter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	I god	and							
Г	Examiner			Due to (was a	consequence of):							
L,		Jer	if any, leading to immediate	Due to (or as a	consequence of):							
٧	cuted	Examiner	cause. Enter Underlying Cluse (Disease of Injury) that initiated events)								
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence of);							
687	ifficate g phys as the	ledic		1								
Box	es that the death certific igned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death	Ectopic pregnanc	у		23d. Date of	,		
0	the dea	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death 5	i ☐ Other (specify) _		-				
Q	s that i	by Ph	Part II. Other significant conditions cor	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?		
Records,	w requires been sign should be	ed b	Diables	H.	per chale	simplosed		1 🗆 Y	es 2 🗆 No 🤌	Probably 4 Unknown		
000	ne law re has bee ge 2 sho	Completed	Heat Dixers					24a. Was a autops		re autopsy findings available or to completion of cause of		
Ä	The Tate has page	Com	Hyle Rennon					perform	med? dea	ith? I Yes 2 □ No		
Vital	ician: Th certificate rector, pag	Be	25. Was calle referred to medical examiner?	tocaital:		04		th (Check only on	10)			
of	tding Phyelcian: th. After this certifica funeral director, p	2 1	1 ☐ Yes 2 No ☐	fospital: 1 _ Inpatient		ent 3[] DOA	her: 4 Nursing H		ence 6 Other			
on	ding h. After funer	tion	1 Natural 5 Pending	28a. Date of Injury (Month, Day	rear) Injun	Wo	rk?]Yes 2 □ No	200. 0030100 11	ow injury occurred			
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	y · At home, farm, (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,		
۵	pitel o		and a set a set is a new in a new in a new in a new in a new in a new in a new in a new in a new in a new in a	Indiana Taraha Barana								
	Hos 1 24 hos 1 E Fun	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	red at the time, d	ause(s) and mann late and place, and	er as stated. I due to the cause(s)		
	To the withing To the comp	Ž	29b. Signature and title of certifier			29c. Licens		2	9d. Date signed (Month, Day, Year)		
•			1 the			D	005632)	9/2	6/02		
	MXI		30. Name and address of person who co	- 111 1	. 13	e, Print)		- 211	1	1		
			31. Date filed (Month, Day, Year)	32. Registrar		4 Ste 3/2	Ellan 1	nD 3/ds	4			
	Sta Registi	State										
DH	MH 17 Rev 1/2	001	23.032	1	Sand Side of							

			For State Registrar	State	of Marylan	id / Depa <i>Cei</i>	artment of H	lealth and Death	d Mental Hy	gie 2e 0	05	31980
	Physicia		1. Decedent's Name (First, Middle James E. Jol						2. Date of De Month Septem	Day	Year 200	3. Time of Death 15 12:45 A M
	/Medic Examin		4a. Facility Name (If not institution		number)		4b. City, Town, o	Location of De			nty of Deat	
		ŧ	Anne Arundel 1				Annapo		Iso To D . (D)		e Aru	
	Funeral Director		5. Social Security Number 216–22–2121	6. Sex 1 → M 2 □ F	7. Age (In yrs. 78	rast birthday) Yrs.	Months Days	If Under 24 H Hours M	8. Date of Bir (Month, Date 2–18–1	y, Year)		hplace (State or Foreign ountry)
		ŀ	Usual Residence of Decedent	Λ	70				2-10-1	941	ATL	ginia
	inylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	Maryland Anne 2	Arundel		E	dgewater		· · · · · · · · · · · · · · · · · · ·	10g. Citizen	of What Co	
	death with the Maryland ms 23a or 28a-f show r must be notified at		515 Brentwood	Rd.			210	37		USA		ond y :
	death	Funeral	11, Marital Status	12. Was De	ecedent Ever in U Forces?	.S. 13.			(Specify Yes or No Jerto Rican, etc.)			orican Indian,
8	or ite		1 Never Married 2 Mar	ried 1X1Yes	s 2 □ No Give		1 ☐ Yes 2 💢 No	Specify:	onto moan, etc.,		city: Wh	
2-0030	within 72 hours after ene. than "natural", or Ite	ed by	3 Widowed 4 Divorced	Year or	Dates:1945-	1	dent's Usual Occup	ation		16b. Kind of		
<u>.</u>	n "na n "na	plet	(Specify only higher Elementary/Secondary (0-12)	est grade complete	d) a (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of t	working			,
7	be filed within 72 hours after death with the Marylan Hygiene. A Hygiene. I show do ther than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	2		, (1 401 01)	Dri	ver			1		Frailer
	2 should be filed within and Mental Hygiene is marked other than aumatic event, ILE Me	Be	17. Father's Name (First, Middle, Massie Jo						Name <i>(First, Middle</i> Lie Hicks	, Maiden Surr	iame)	
_	s 1 and 2 should f Health and Men item 27 is marke other traumatic	ဥ	19a. Informant's Name/Relations			19b. Mailii	ng Address (Street		Rural Route Numb	er, City or Tox	wn, State, 2	Zip Code)
Z Z	nd 2 s alth ar 27 is r trau		Irene M. Johns						Edgewater			
e,	es 1 a of Hea ritem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		- Ctata	cemetery, crei	sition (Name of natory or other place		Date			Town, State
Saltimor	Page ment ant: I		*4 ☐Donation 5 ☐ Other (S	Specify)	La		Cemetery		-17-05			ille, MD
Rail	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signature of Funeral Service	Licensee		2	2. Name and Addre	ss of Facility (George P. Land Rd. 1	Kalas Edgewat	Fune:	ral Home ND 21037
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that tonly one cause or	at caused the deat in each line.	th. Do not ent	er the mode of dyin		diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a conseq	quence of):						/
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due t	to (or as a conseq	quence of):						
_	icate be executed physician and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a consec	quence of):						
8/60,	e be ei rsician e buria	dical E		d		. ,						
٥	tificate ng phy as the	Φ	IS SENALS									
ROX	leath certific attending p I for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pregna e birth 2 Peta	aldeath 3[Ectopic pregnancy	,			Date of deli	ivery Day Year
o.	at the dea	ysic	1 □ Yes 2 □ No 9 □ Unknown	4∐Pre 9□Uni	egnant at time of c known	1eath 5L	Other (specify) _					
ري ت	res that i igned by be deta	by Ph	Part II. Other significant conditi	ions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use c	ontribute to	the cause of death?
ecords,	w require been sig should b	ted k							_ 10	Yes 2□No	3 □ Pr	obably 4 Dunkdown
Kecc	has has	Completed				·····			24a. Was auto perfo	psy ormed?	prior to death?	utopsy findings available completion of cause of
Vital	(0	a	25. Was case referred to medica	al				26. Place of I	1 ☐ Yes Death (Check only o	2 ZNo	1 🗆 Yes	2 1
<u> </u>	nysich	To B	examiner? 1 Tes 2 No	Hospital:	Patient 2	ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursin	g Home 5 ☐ Resi	dence 6 🗆	Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	ing (M	te of Injury lonth, Day Year)	28b. Time o Injury	Wor	k?	28d. Describe	how injury occ	curred	
Division of	Attendi death. ctor: A y the fu	icat	2 Accident Invest 3 Suicide 6 Could		ace of Injury - At h	ome, farm, st	M 1 □	Yes 2 □ No	28f. Location (Street and Nu	ımber or Rı	ural Route Number,
<u>></u>	al or A s after of in by	Certification:	4 ☐ Homicide determ	mined 200. Fig	ilding, etc. (Speci	fy)	,,,			wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	I Examiner: On the	the best of my kno e basis of examina anner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) and date and place	manner as e, and due	s stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certify	P/ /			29c. Licens	e number	0.	29d. Date/sig	ned (Monti	h, Day, Year)
			MU	100			U/n	55 4	74	7/1	3/2	009
			30. Name and address of person	the completed ca	ause of death (Iter	m 23a) (Type,	Anud	e she	dice	cent	20	
	Sta Registi		31. Date filed (Month, Day, Year SEP 1		Aegistrar's Sign	ature d	med					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygions

•			1 - For State Amend Item 1 Registrar 1. Decedent's Name (First, Middle, La	RUnpend Item 2	Jones	8a-f per i	2	Date of Death		3 98 3. Time of Death
	Physic /Medi				L. Jo	nes-		Septembe:	21, 2005	10:18 AM
	Examir	ner	4a. Facility Name (If not institution, give Prince George's H		r	4b. City, Town, or Lo Cheverly			4c. County of Death	
35,1	Funeral Director		5. Social Security Number 214-73-3358 6. S			If Under 1 Year If	Under 24 Hrs. o	Date of Birth (Month, Day, Ye INC 24,	Prince Geo 2005 Mary	orge 's place (State or Foreign pland
_	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Loc	ation				10d. Inside City Limits
	Mary I sho	tor	Maryland Prince	George's		Lanh	am			1X Yes 2 No
	death with the Maryland me 23a or 28a-f show f must be nydified at	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
	e 23a	eral [6903 Elbrook			2070			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "netural", or Iteme 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐Yes 2M No If Yes, Give Year or Dates:	If	/as Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2X No S	inic Origin? (Specif Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: B]	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedo	ent's Usual Occupation	n na most of workina	16b	. Kind of Business/In	
121	within ene. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	None	g moot or norming		None	
9	filed Hygin other	Be Cc	17. Father's Name (First, Middle, Last)				. Mother's Name (F	irst, Middle, Maid	None	
/lan	wild be Mental wrked c	To B	Arthur Jones, 3	Jr.			Tra	cy Dorse	² Y	
, Maryland	and 2 sho salth and I n 27 ie ma		19a. Informant's Name/Relationship (i Tracy Dorsey (i	• • • • • • • • • • • • • • • • • • • •		Address (Street and Elbrook Ro				Code)
Baltimore,	Pages 1 ent of He nt: If Iten ry or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		ition (Name of atory or other place) Cemetery	9/29/2		Location - City or To	
alti	permit. Page Department of Importent: If eny Injury or once.	i	21. Signature of Funeral Service Liben		_	Name and Address of				
8	8358		fatrices)	demire	69	06 Kent To	own Drive	, Landov	er, MD 20	7 85
	Physician /Medical		23a. Part1. Enter the disease, or copy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Sudden Unexp	lained					Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a conseq						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	tuence or):					
68760,	tificate be executed g physicien and as the burial-transit	ledicai Exa	resulting in death) Last	Due to (or as a conseq	quence of):					1360
			IF FEMALE:	220 16 1000 01100 01100						
P.O. Box	The law requires that the death cert lie has been signed by the ettendin vage 2 should be detached for use	by Physiclan/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1	ıl death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
	w requires that been signed should be de		Part II. Other significant conditions or	ntributing to death but not res	ulting in the unc	derlying cause given in	Part I.		ouse contribute to the	ne cause of death? ably 4 Dunknown
Division of Vital Records,		Completed						24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
Vit.	Physicien: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital:		1 04	Place of Death (C.	100		
o	ig Phya ter this neral di	F 1	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injury at Work?		5 Residence	6 Other (Specify	unk
sior		atio	1 Natural 5 Pending 2 Accident investigation	0 04 04	Found:	A ^M 1 ☐ Yes	2 X No			
Νį	or Att	Ĕ	3 ☐ Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	et, factory, office	28f.	Location (Street a	and Number Rura	Route Number ner Avenue s,Prince
J	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification;	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	Residence sician: To the best of my kno ner: On the basis of examinat	wledge, death of	occurred at the time, di	oto and place and	THE S OF	ounty, in	
	To the within 2 To the 5 complete	Med	one) 29b. Signature and title of sentiller	and manner stated.		-				
	F ≱F 8		· MARA	KIN		29c. License nun			ate signed (Month, L	
00	,	-	30. Name and address of person who c	ompleted cause of death (Item	1 23a) (Type, Pr	0.C.	M.E.	Sep	tember 22,	2005
UK			S.R. 1400	JAN	111	Penn Stree	t, Baltin	nore, Man	cyland 212	201
	Sta Registra	.6	31. Date filed (Month, Day, Year) SEP 2 8 2005	2. Registrar's Signa	ford					

DHMH 17 Rev 1/2001

		1 - State of State of Registrar	f Maryland		artment of				iene g. 2005	31982
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Grafton Paul	Jones					2. Date of Death Month		3. Time of Death
Examin		4a. Facility Neme (If not institution, give street and nu Futurecare Nursing			Ar	n, or Location nold				rundel
Funeral Director		5. Social Security Number 220-40-6278 G. Sex MAN 2 F Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da		Min.	B. Date of Birth June 20	, 1941 M	Birthplace (State or Foreign Country) laryland
the Maryland 28e-f show notified at	rector	10a. State 10b. County Maryland Calvert 10e. Street and Number	10c. City,	Town or Lo		peake	Bea		ng. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 📈 No It Country?
ges 1 and 2 should be filled within 72 hours after death with the Maryland rid Health and Mental Hygiene. 11 of Health and Mental Hygiene. 12 of Health and Mental Hygiene. 13 or other traumatic event, the Medical Examination routined.	/ Funeral Director	1 Never Married 2 T Married 1 Yes	edent Ever in U.S. orces?		Was Decedent of Yes, specify C		rigin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	Black, V	American Indian, White, etc. Black
within 72 hours sne. then "natural",	Completed by	3 Widowed 4 Divorced If Year or D 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2		16a. Dece (Give life.	dent's Usual Ockind of work do DO NOT use re	cupation ne during mos tired)		g	16b. Kind of Busin	
nd 2 should be filed within all and Menta! Hygiene. 27 Is marked other then in traumatic event, Item.	To Be Co	17. Father's Name (First, Middle, Last)	Jones,			18. Moth	er's Name (Maiden Sumame) Out	
and 2 shored to a street to a	1 2	19a Informant's Name/Relationship (<i>Type, Print</i>) Nancy H. Jones/Wife		P.0	. Box	552	Chesa	apeake		MD 20732
Deficiency, we permit. Pages 1 and 2 Department of Health a Important: If them 27 to any injury or other tra		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 □ Removal from '4 □ Donation 5 □ Other (Specify)		Get	sition (Name of matory or other h.Chr.	Cem.		/05		town, MD
permit. Departr Imports any inji		21. Signature of Funeral Service Licensee Service Licensee Servic	elf	1	Name and Ad 451 Da	res b	iv Sev each	well F Rd.Pr	uneral ince Fr	ed.,MD20678
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a conseque	E Rence of):						Approximate Interval Between Onset and Death
w requires that the death certifical requires that the death certifical been signed by the attending problem to detached for use as the	Physician/Me	is the past 12 months?	tcome of pregnand birth 2 Petal d nant at time of dea own	death 3	Ectopic pregna Other (specify				23d. Date of Month	f delivery Day Year
w requires that been signed be should be detailed		Part II. Other significant conditions contributing to d CORONARY ARTER		-		given in Part	l.			te to the cause of death? Probably 4 Unknown
i: The law recate has been a page 2 sho	Completed by	PERIPHERAL VAS	euin	2 D	ISEAS	E		24a. Was ar autopsy perform 1 Yes 2	y prior ned? deat	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No
VICA aician: s certific lirector,	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Hospital: 1	Inpatient 2□E	R/Outpatier	it 3□ DOA			(Check onlv one e 5 □ Reside	e) nce 6 □Other <i>(</i>	Specify)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, Ther this certificate has completely filled in by the funeral director, page 2.	ertification; To	27. Manner of Death 28a. Date		28b. Time o	28c. l	njury at Work? 1 Yes 2	28		w injury occurred	, , , , , , , , , , , , , , , , , , ,
tal or Atters after de el Directo	Certific	3 Suicide 6 Could not be determined 28e. Place build	e of Injury - At homing, etc. (Specify)	ne, farm, str	eet, factory, off	ice	28	Bf. Location (Str City or Town	reet and Number o , State)	or Rural Route Number,
the Hospi in 24 hour the Funer ipletely fill	edical				vestigation, in n	ny opinion, dea		d at the time, da	ite and place, and	due to the cause(s)
To T To T COLL	M	29b. Signature and title of certifier Money, Ma	,		1			3		2,2005
4 Sta	to-	30. Name and address of peter who completed cau Mohu Nes 31. Date filed (Month, Day, Year) 32. F	se of death (Item 2 76 01 U Registrar's Signatu	23a) (Type, IECL, ure	Print)	dwy,	Mil	dersi.	ille, M	W 21/08
Registr		SEP 1 4 2005 Elecus	Registrar's Signatu	park	,					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Month Year **Physician** Onnie Mae Kifer Reptember 3005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Grace De Marford Fizens NURSing Home Yarre | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 17, 1914 9. Birthplace (State or Foreign Country) Washington 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F Months 90 218-09-9062 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 le markad other then "natural", or Iteme 23a or 28a-f show othar traumatic evant. The Medical Examiner must be notified at 1⊠Yes 2 No Director Maryland Perryville Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 949 Broad Street 21903 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is markad other than "natural", or Itel 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 2 White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Perry Point, Maryland Three Years Housekeeping Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John R. Boothe Lucy Sparks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health an ant: If Item 27 len 949 Broad Street, Perryville, Maryland William J. Kifer (son) 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Principio Cemetery 09/19/05 Perryville, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) enu draleur Priysician /Medical Due to (or as a consequence): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of) Examiner burial-transit Due to (or as a consequence of): ettending physiclan for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ menlea 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 🗆 No 1 Yes 2 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred al or Attanding Patter death.

Director: After 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 16/05 32609 Mans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamnucky Nulham M Noc Revolution S.+ avre De Grane H 31. Date filed (Month, Sar, 1981) 9 2005 32. Reistrar's Signature State Registrar

noe

			For State Registrar	State of M	arylan			nt of Heate of De			giene 0 0 5	31984
P .	Physici		Decedent's Name (First, Middl RUTH	e, Last) E			T.AY	TON		2. Date of De Month	Day Ye	3. Time of Death
	/Medic		4a. Facility Name (If not institution						cation of Deat		4c. County of [
ž.	Funeral Director		S. Social Security Number 219-38-6682	1000 Nedia 6. Sex 1 M 2 N F 7. As	10/ Ge 10 (In yrs. 64	last birthda Yrs.	y) If Under		Under 24 Hrs Hours Min.		th y, Year) 9.	Birthplace (State or Foreign Country) ST VIRGINIA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or	Location					10d. Inside City Limits
	Maryl f aho	ō	DE SI	JSSEX	DF	LMAR			,			1 ☐ Yes 2 💆 No
	death with the Maryland ms 23a or 28a-f ahow	rec	10e. Street and Number				10f. Z	p Code			10g. Citizen of Wha	t Country?
	th wit	a D	10411 HARNS P	VT. WAY				19940)		USA	
	172 hours after death with the Marylan "natural; or Itams 23a or 28a-1 ahow circal Exeminer must be multified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ፟ Widowed 4 ☐ Divorced	Wyor Cino		.S. 13	B. Was Dece If Yes, spi 1 Tes		anic Origin? (S Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Black, \Specify:	American Indian, White, etc. WHITE
5	72 ho	Completed		t's Education st grade completed)		16a. Dec	cedent's Usi	ual Occupatio	n ing most of wo	rkina	16b. Kind of Busin	ess/Industry
	C	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)	life	. DO NOT	use retired)	ng most or no	, Anny	17777	
A	be filed within ital Hygiene. id other than avant, ire M		9 17. Father's Name (First, Middle,	l act)		COC)K	16	Mother's Nar	no (Eiret Middle	NURSING Maiden Sumame)	HOME
	D E D E	To Be	RUBY	WALTER			SETLE		BERTHA	ne (First, Middle,		HARDY
a Z	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Ma	iling Addres	s (Street and	Number or Ru	ırai Route Numbe	er, City or Town, Sta	te, Zip Code)
₹, ₹	and ealth m 27 her tr		WILLIAM CLARKE-	- SON	005 0	_			. WAY I		DE 19940	
20			20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State		emetery, ci	position (Na rematory or	other place)		Date	20c. Location - City	or Town, State
	permit. Page Department o Important: If any injury or price.		4 Donation 5 Other (S		LE		EMETE		9/19	9/05	WILLARDS	, MARYLAND
Ö	Depared Depared Impo		21. Signature of Funeral Service 23a. Part Enter the disease, or shock, or heart failure. List	Key Lee	uup		705 E	ind Address o	STREET	SALISB	UNERAL HOUNEY, MD 2	
	Certificate be executed for the private transit transi	Ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Mejus Due to (or as b. Due to (or as c	a conseq a conseq	uence of):	pho	lopat	Ay_		ch to Live	3 ctay 10
.O. DOX 00	certific iding p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 20 No 9 □ Unknown	23c. If yes, outcome 1 \(\subseteq \text{Live birth} \) 4 \(\subseteq \text{Pregnant a} \) 9 \(\subseteq \text{Unknown} \)	2 Feta	I death 3	B⊟Ectopic (23d. Date of Month	f delivery Day Year
cords, r	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be detached for u	þ	Part II. Other significant conditions of the control of the contro	ons contributing to death b		•	, ,	cause given i				te to the cause of death?
vitai nec	n; The law ficate has b or, page 2 st	e Completed	25. Was case referred to medica					75117000		1 ☐ Yes	prior deat 2 No 1 🗆	
5	s cert	0 8	examiner?	Hospital:	ent 2 🗆	EB/Outpati	ent 3 🗆 D	Othor		ath Check only o	ne) dence 6 □Other(;	Specify)
Ö	nding Phy ath. r: After thi e funeral c	-	27. Manner of Death 1. Natural 5 Pendir 2 Accident investi	28a. Date of Inju		28b. Time Injury		28c. Injury at Work?			now injury occurred	эроспу
	ital or Atte irs after de rsi Diracto led in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At ho	ome, farm, s	street, facto	ry, office		28f. Location (\$ City or Tox	Street and Number o vn, State)	or Rural Route Number.
	Hosp 24 hou Fune etely fil	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis o and manner st	f examina	wledge, de tion and/or	ath occurre investigatio	d at the time, n, in my opini	date and place on, death occu	e, and due to the erred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	vithin omple	Me	29b. Signature and title of certifie				29	c. License n	umber		29d. Date signed (M	fonth, Day, Year)
	, 0 4 5		Pau :	- Che	- W	D		D001	4314	-	Sept 16.	2005
	36		30. Name and address of person					(87	FET			mo 21801
	Sta								<u>/,</u>	011 = 13	isury,	01000
	Registr	ar	OEP I	A TOUS	18 1	K	Smel.	,				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar 31985 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death sept.8, 2005 **Physician** 5:30a M John LeGrande Austin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Temple Hills P.G. 1877 Iverson Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 1947) 1935 9. Birthplace (State or Foreign Va.) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 DM 2 F 70 Yrs Director 227-40-2706 Usual Residence of Decedent the Maryland 10c. City. Town or Location 1∩a State 10b. County 10d. Inside City Limits 28a-f show ir than "natural", or Items 23s or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Temple Hills P.G. Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20748 1877 Iverson St, Temple Hills death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 25 Married Specify BLAck Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nat any Injury or other traumatic event, the Medica once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Carpenter 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Asher John Thomas LeGrande 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1877 Iverson St.Temple Hills Md. 20748 19a. Informant's Name/Relationship (Type, Print) Elnora LeGrande -Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Spring Hill Ch 9-13-2005 Brookneal, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons 5635 Eads St, N.E. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPERTENSIVE CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetel death in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 MYELOMA 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 280 No 1 Yes 1 Yes 25 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl 24 hours after death. ne Funeral Director: After the Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ع M.D D3038 dre THEM - 5007 30. Name and address of person who completed cause of de th (Item 23a) (Type, Print) D12 CATAWAY 12 d INTOM . Registrar's Signature-31. Date filed (Month, Day, Year) State SEP 1 9 2005 Registrar

			1 - For State Registrar	State of Maryland / D	epartment of I Certificate of		, ,	0000 01000
	Physici	an	Decedent's Name (First, Middle, Last) THOMAS J.		oor.medico or	Dodin	Reg. 2. Date of Death Month SEPT 1	оду 6 20°05 10:57Р м
,	/Medi Examir		4a. Facility Name (If not institution, give : SOUTHERN MARYLA			or Location of Death		4c. County of Death P.G.
l p	- Funeral	×	5. Social Security Number 6. Sex	7. Age (In yrs. last birth			8. Date of Birth Month, Day, Ye.	9. Birthplace (State or Foreign
2	פ		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		70112 2 .	10d. Inside City Limits
	e Maryli sa-f eho liffed a	ctor	D.C.		ASHINGTO	1		1 XYes 2 No
	th with th	al Dire	10e. Street and Number 520 OAKWOOD	ST., S.E.	10f. Zip Code	20032	10g.	Citizen of What Country? USA
036	within 72 hours after death with the Maryland ene. than "natural", or flema 23e or 28e-f ehow ta Madical Exeminar mast be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 □ No HYes, Give 1 9 5 1 / 1 9 5 Year or Dates: 9 5 1 / 1 9 5		an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Heath and Mental Hygiene. If itam 27 is marked other than "natural", or itema 23s or 28s-1 show or other traumatic event, If a Practical Examinations is a notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) (Decedent's Usual Occu Give kind of work done life. DO NOT use retire SUPERVI:	during most of wor	king	FED. GOVT.
Maryland 2	should be filed nd Mental Hygin marked other umatic event, ti	To Be C	17. Father's Name (First, Middle, Last) HORACE MAT	THEWS		18. Mother's Nam	ne (First, Middle, Maid HARRIS	len Surname)
	and 2 sho Balth and I n 27 is ma		19a. Informant's Name/Relationship (Ty) BRENDA M. BOSWE	coe, Print) CLL/DAUGHTER 5!	Mailing Address (Street	and Number or Ru MICK RD	ral Route Number, Cit	y or Town, State, Zip Code) , N.C. 27713
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other ance.		20a. Method of Disposition Burial 2 Cremation 3 R Donation 5 Other (Specify)	emoval from Statecemetery,	Disposition (Name of crematory or other plant NCOLN CEI	4. 9/24	1/05 BF	Location - City or Town, State RENTWOOD, MD.
Balt	permit. Depart Import any inj		21. Sign, tule of Funeral Service License	ee _	22. Name and Addre 3435 14	th ST.,		
68760,	Physician by physician and physician and sthe purish transit sthe purish transit	edical Examiner	23a. Part1. Enter the disease, or complishook, wheart failure. List only on Immediate Cause (Final disease or condition resulting in death) Securation y ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ryoCa):			Approximate Interval Between Onset and Death
P.O. Box 6	death certii e ettending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnanc; 5 ☐ Other (specify) _	(23d. Date of delivery Month Day Year
	The law requires that the to has been signed by the bage 2 should be detache	þ	Part If. Other significant conditions con	tributing to death but not resulting in t	he underlying cause giv	en in Part f.	23e. Did tobacco	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
al Records,		Completed					24a. Was an autopsy performed?	
Vita	ysiciar is certif director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: patient 2 ER/Outp	atient 3 □ DOA Oth	00	h Check only one) ome 5 - Residence	6 Mother (Second)
Division of	ding Ph	atlon: T	27. Manner of Death 1 Deatural 5 Pending 2 Accident Investigation	28a. Date of Injury 28b. Tim (Month, Day Year) Inju	ne of 28c. Injur		28d. Describe how in	
DIVIS	in Pige	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Physical Check only ons) 1 Medical Examin	cian: To the best of my knowledge, on the basis of examination and/or and manner stated.	death occurred at the tir or investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signatule and title of entifier		29c. Licens	e number		Pate signed (Month, Day, Year)
)	1	-	30. Name and address of person who cor	npleted cause of death (Item 23a) (Ty	Ope Print	154	Seg	plenskes, 17, 05
_	(0)		9801 / 1000	Sia Ave 3 -cel	8, Ivens	PRING	MD 209	~ ~
	Sta Registr	_	31. Date filed (Mofith, Bay, Year) SEP 2 0 2005	2. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrer Reg. 2.005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MICHAEL SEPTEMBER 17,2005 CALLIE JEAN 2350 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL ALLEGANY CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Str. Months | Days | Hours | Min. | March | 25,1931 | Arkansas 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 210 F 432-54-2183 Yrs. 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic avant, the Medical Exercitors Legisled at 1 ☐ Yes 2x No Director Garrett Grantsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked othar then "natural", or Itams 23e 21536 USA 61 Red Ridge Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: þ White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vera Merritt Elbert Whitson ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perruit. Pages 1 and 2 sh Deputriment of Health and Important: If itam 27 is it any injury or other traum once. Nancy J. Ruff/Daughter 879 Meyersdale Road, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Grantsville Cemetery Sept. 21,2005 Grantsville, MD * 4 ☐ Dorfation 5 ☐ Other (Specify) 21. Signature of Fune of Service Licens 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD luma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEFT CEREBELLAR INFARCT **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi HYPERTENSION and resulting in death) Last Due to (or as a consequence of) attending physician P.O. Box 68760, Physician/Medical use as the IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ias been signed by i 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 No Division of Vital 1 Yes the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 / Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 🗌 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier Medical 🅦 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 mysician 63118 SEPTEMBER 18. 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Seton Dr. Cumberland, MD 21502 Hos pitalis WIRASAT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

			1 - For State Registrer		State of Ma	aryland	l / Depa <i>Cer</i>	irtment of H <i>tificate of I</i>	lealth and Death	Mental Hy	gien Reg. N	2005	3	319	88
	Physici		1. Decedent's Nam	e (First, Middle, Las	Joseph A	. Mangi	alardo			2. Date of D Month Sept. 16	D	ay Ye	ar	3. Time o	
A. S. C.	/Medic Examin		4a. Facility Name (/	If not institution, give	street and number)			4b. City, Town, or	Location of Deat			c. County of D		11.20	
76			Holy Cross	Hospital				Silver Sp	_			ontgamer	у		
	Funeral Director		5. Social Security N 577–48–937]		ex 7. Ag	e (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Ye <i>a</i> i ,193	9. 1 5 Was	Birthpla Country Shing	ce (State y) ston, D	<i>or Foreig</i> n C
	and and		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation					100	d. Inside C	City Limits
	Maryl -f sho	į	Maryland	Prince Geor	rge's	Temp	le Hill	s						1 🗌 Yes	s 2 No
	or 284	Directo	10e. Street and Nu					10f. Zip Code				itizen of What	Country	y?	
	eath w	Funeral	5004 Hender	son Road	12. Was Decedent	Ever in U.S.	. 13. V	20748 Vas Decedent of Hi	ispanic Origin? (S	ipecify Yes or N	USA	14. Race - A	mericar	Indian.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumatic event, the Medical Examinat must be notified at	by Fun		ied 2 Married 4 □ Divorced	Armed Forces? 1 1 Yes 2 □ 1 If Yes, Give Year or Dates:		_ ff	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puer Specify:	to Rican, etc.)		Black, W Specify: W	/hite, etc		
2-00	72 hou natura ilcul E			15. Decedent's Ed	lucation	1701	16a. Deced	ent's Usual Occupa	ation during most of wo	rkina	16b.	Kind of Busine		stry	
Maryland 21215-0036	within ene. then "	Completed	Elementary/Seco		College (1-4or 5	i+)	Self-er	kind of work done of OO NOT use retired)		2	.			
d 2	filed Hygie other ent, t	Be Co	17. Father's Name	(First, Middle, Last)			зеп-а	пртоуец	18. Mother's Nar	me (First, Middle	De , Maide				
/lan	2 should be and Mental is marked of reumatic ever	To B	Antonio	Mangiala	rdo				Anna Cal	abrese					
Jan	2 sho and i			ame/Relationship (7 Mangialardo	** *			g Address (Street a			-	or Town, State	e, Zip C	ode)	
e, l	os 1 and 2 of Health Item 27 i		20a. Method of Dis		D/ WITE	20b. Pla	ce of Dispos	enderson Rd sition (Name of	· •	Dete 2		_ocation - City	or Town	n, State	
altimore,	Pages nent of int: If It			Cremation 3 5 Other (Specify	Removal from State		ont Men	natory or other plac norial Gard	ens 9/20/	05	David	dsonville	∍. Ma	1.	
Balti	permit. Pages Department of Importent: If I any injury or once		21. Signature of Fu	uneral Service Licen	\$00 LA (-)	-	22.	Name and Addres	s of Facility Geo	rge P. Ka	las I	Funeral E	Tome		
			23a. Parti. Enter t	he disease, or comp	olications that caused one cause on each lin	the death.						1-15	A	oproxima nterval Be	ite itween
	Physician		Immediate Cause disease or condition	(Final	a. Advanced 1								C	nset and	Death
	/Medical Examiner		resulting in death)	ſ	Due to (or as Respirato										
		ner	Sequentially list co	nditions, nmediate	Due to (or as								-		
	ecuted and -transi	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death)	; .	c. Cardiac A		nce of).						-		
68760,	ficate be executed g physician and as the burial-transit	edical E			d										
68		Medi	IT PENALE.												
.O. Box	that the death certificated by the attending posterior of detached for use as	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[9 Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of o Month	delivery Da	ay	Year
Д	95 PB	by	Part II. Other signif	ficant conditions c	ontributing to death b	ut not result	ing in the un	derlying cause give	en in Part I.			use contribute			death? Unknown
Sorc	w requir been si should	eted								24a. Was		24b. Were			
Vital Records,		Completed								auto		prior t	to comp	letion of d	cause of
Zij.	Physicien: The this certificate rated director, pag	o Be	25. Was case refer examiner? 1 ☐ Yes 2 🟋		Hospital: XX Inpatie	nt 2 🗆 🗆	R/Outpatient	3□ DOA Othe	26. Place of Dea	ith (Check only		8 TO:hay (C	16.1		
of	g Physicar this	n: To	27. Manner of Deat	h	28a. Date of Injur (Month, Day	y 2	8b. Time of Injury	28c. Injury Work		28d. Describe			респу)		
slor	Attending Fr death. sctor: After by the funer	catlo	1 XNatural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not be				M 1 🗆 Y	res 2 □ No						
Divislon	el or Attenos after deatl	Certification:	3 Suicide 4 Homicide	determined	28e. Place of Inju building, etc	ury - At hom c. (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To			Rurai R	loute Nun	nber,
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one)		ysicien: To the best of niner: On the basis of and manner sta	examinatio									s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	lle	1		29c. License D32247	number			ate signed (Mo		y, Year)	
)	(6)				completed cause of do			,	. 20910						
Ĭ	Sta	_	31. Date filed (Mon	th, Day, Year)	32. Registra				•20710						
	Registr	ar	SEP	1 9 2005	Distres	,	4								

			1 - For State Registrar	State of Ma	-	•	ment of He		Mental Hyg	giene () ()5	31989	
	Physici	20	1. Decedent's Name (First, Middle, La	-					2. Date of Dea Month	ith Day	Year	3. Time of Death	
3	/Medic			Leroy	Muth		- O'- T	Landing of De	Septemb			6:30 P M	
	Examin	er	4a. Facility Name (If not institution, gines 1413 Cape St. Cla			4	b. City, Town, or		am		ity of Death	- 7	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birt		f Under 1 Year	polis If Under 24 H		1	Arund 9. Birthp	CL lace (State or Foreign try)	7
	Director		174-20-7190	1 ∆ M 2□ F	77	Yrs.	onths Days	Hours Mi	n. (Month, Day May 25	, 1928		sylvania	
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locat	ion				1	Od. Inside City Limits	
	Maryli f sho	ō	Maryland Anne Aru	indo I	,		Annapol	ic				1 ☐ Yes 2 🛣 No	
	28e	Director	10e. Street and Number	muer			10f. Zip Code	12		10g. Citizen o	f What Coun	try?	_
	h with		1413 Cape St. Cl	air Road			214	09		$U_{\bullet}S$	5.A.		
	ems ?	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1945-	13. Was	s Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)		ace - Americ ack, White,		
36	within 72 hours after death with the Maryland ane. then "neturel", or items 28a or 28e-1 show he Madigal Examinar must be rotified at	by Fu	1 Never Married 2 Married	1X Yes 2 ☐ f			Yes 21 No	Specify:	,	Spec	ihe	_	
21215-0036	hour turel		3 Widowed 4 Divorced 15. Decedent's E	Year or Dates:	16a.	Decedent	t's Usual Occupa	tion		16b. Kind of		ite Justry	
15	n "ne Nedis	piet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5		(Give kin	d of work done di NOT use retired)	uring most of w	rorking			,	
212	giene grene er the	Completed	12	College (1-401 C	,+,		Inspect	or		Gas ar	id Ele	ctric Co.	
Maryland	d 2 should be filed within h and Mental Hygiene. 7 Is marked other then "treumatic event, the Mes	Be (17. Father's Name (First, Middle, Last						ame (First, Middle,	Maiden Suma	ımə)		
<u>Ş</u>	d Men narke	P	Kenneth Mu		10h	Mailine A	Address (Chanada)		Unknown	- Chi - T-	- Ct-10 Tin	Cordo)	
Z	d 2 sl th and th and treur		19a. Informant's Name/Relationship Doris E. Muth (N		Rural Route Numbe Rd. Annaj			•					
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygtene. Item 27 Is marked other then "neturel", or items 25a or 28e-1 show other treumatic event, The Madical Examinar must be notified at		20a. Method of Disposition	<u>-</u>	Date 2005				_				
9	Pages lent of lift: If I		1 ☐ Burial 2X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci				ory`or other place Cremato.		t. 22,	Smithsb	ourg,	Maryland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importekt: If Item 27 Is any Injury or other tre-		21. Signature of Funeral Service Lice	nsee		22. N	ame and Address	of Facility	J.L. Davi				1
8	90 E 2 9	_	Teller les	Davis	MO1414				e. Smiths		MD 21		
			232 Part Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. Do n	not enter ti	he mode of dying	3		est,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HEA	LA AN	7	ECK	ANCE	R		V	WO YEAR	۷
	Examiner			Due to (or as	a consequence o	of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence o	of):							
V	rcuted nd transit	Examiner	that initiated events	c									_
90,	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence o	of):							
8760,	cate ohy:	dicai		_ d									-
Box 6	The law requires that the death certific tle has been signed by the atlending p tage 2 should be detached for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. D	ate of delive	v	Ī
	death e atter	Physician/M	in the past 12 months?	4 Pregnant at	2 Fetal death time of death		topic pregnancy ther (specify)					Day Year	
P.0	at the de by the a stached	hys	9 🗆 Unknown	9□ Unknown									_
	igned I	by	Part II. Other significant conditions	contributing to death b	ut not resulting in	the unde	rlying cause giver	n in Part I.		3.6		e cause of death?	
Records,	w require been si	Completed							1 □ Y		3 [] P100a	ibly 4 Unknown	
3ec	e law has b	mple							24a. Was a autops perfor	sy		sy findings available pletion of cause of	
a			25. Was case referred to medical				 -		1 ☐ Yes	200	1 ☐ Yes	2 🗆 No	
Vital	Physicien: this certificaral director, I	o Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Out	tnatient '	3□ DOA Other		eath (Check only or Home 5 keesid	-/	har (Specific	1	
of	<u>t</u> + <u>e</u>	-	27. Manner of Death	28a. Date of Inju (Month, Day	ry 28b. T		28c. Injury	at	28d. escribe h				
ior	E A P	atio	1 Natural 5 Pending investigation	n	7007			es 2 □ No					
Division	for Att after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At home, far c. (Specify)	rm, street,	factory, office		28f. Location (S. City or Town	reet and Num n, State)	ber or Rural	Route Number,	
	pitet o		29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowledge	doath	average at the time	data and plac	o and due to the e				17
	e Hos 24 hc Fun etely	edical	(Check only one)	miner: On the basis of and manner sta	examination and	for invest	igation, in my opi	nion, death occ	curred at the time, d	ause(s) and mate and and are	, and due to	the cause(s)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of cortifier				29c. License	number	2	9d. Date sign	ed (Month, [Pay, Year)	
			1 Witten	- mo			554	563	<	EDTE ON	5 332	7005 5	
	6		30. Name and address of person who	1/	0		t) day say		./\1		5	2005 S	
			Janus Hofk NS 31. Date filed (Month, Day, Year)	YOSP, TAK.	ar's Signature	HORE	MARY.	2000 -	MOTICA	13 A	21050	M ITA	
	Sta Registr	1311	OCT 0 3		J Oignature		- 0						
				TOO?	we st	1	المناوع			3 -			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** THOMAS SEPT. 14 2005 2105 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BERLIN
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) ATLANTIC GENERAL HOSPITAL WORCESTER 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 75 Yrs Director JULY 26, 1930 PENNSÝLVANIA 207-24-9139 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 "natural", or Items 23a 261 MALLARD LAKES USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1956-58 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainment. College (1-4or 5+) Elementary/Secondary (0-12) 5+ BRANCH CHIEF SOCIAL SECURITY ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS Ρ. NOWICKI SR. CATHERINE BARCHOK 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. NOWICKI/WIFE 261 MALLARD LAKES, SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 9/16/05 DELMAR, DELAWARE 21. Signatur Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE RESPIRATORE Immediate Cause (Final SEEDES Ildays Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA STERAL Sacus that flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit moul MCien-150 resulting in death) Last Due to (or as a consequence of): 68760 MYOCARDIA Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an The 1 🗆 Yes 24 No of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 DN0 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Injury 1 ANatural 5 Pending death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2—Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifue 29c. License number 29d. Date signed (Month, Day, Year, 46257 05 EDWIN T. CASTANEDA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROULEVAND OCEAN 9 2005 Registrar

210

Q

0/26/1930

Nowic

Thomas

9130

7

120

14116

EVans A. Pusay SS# 214-10-7727

			Please 7	Гуре or Prin	t in Blac	k Indelibl	e Ink. Er	nsure A	II Copies	Are	Legible.		
			1 - State Registrar	State of Ma	•	Departmer Certifica:			•	giene	11115	31991	
M	. 8		Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death	
	Physicia	_	EVANS	ANDRE	W		PUSEY		Sept	Day Panlo	Year	50410	М
	/Medic Examin		4a. Facility Name (If not institution, give		**		Town, or Loca	tion ol Death			County of Dea	100	
			Peninsula legion	W Medica	1 Cen	ter 5	alish	14			Wicon	rico	
15	Funeral		5. Social Security Number 6. Se	XM 2DE	(In yrs. last bir	thday) If Under Months		urs Min.	8. Date of Bir (Month, Da		C	thplace (State or Foreignantry)	gп
*	Director		214-10-7727 Usual Residence of Decedent	91		113.			APRIL 2	19,19)14 MAR	YLAND	
	ehow		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limit	s
	Mar	tor	MD WICOM	CO		SA	LISBURY					1 ☐ Yes 2X N	0
	or 28a-f	Director	10e. Street and Number			10f. Zi	p Code	İ		10g. Cit	izen ol What C	ountry?	
	ath w	ral	7827 BROWN ROAD				21804				USA		
	ter death w	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dece If Yes, spe	dent of Hispani offy Cuban, Me	c Origin? (Sp xican, Puerto	pecity Yes or No Rican, etc.))-	14. Race - Am Black, Whi		
2	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ZAYes 2 □ N If Yes, Give 1 Year or Dates:	941-44	1 🗆 Yes	2 No Spe	ecify:			Specify:	WHITE	
5	72 hours "natural", idical Exe	ted	15. Decedent's Edu (Specify only highest grad	cation	16a.	Decedent's Usu	al Occupation	most of word	vin a	16b. K	ind of Business	√Industry	
,	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT	ise retired)	THOSE OF WOR	ung.				
7	led will like the the the the the the the the the th		12		0	WNER/OP		Anthodo Nom	e (First, Middle		UTOMOTI	VE	
2	2 should be filed within 72 hours after death with the Maryland and Memlar Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, the Madical Examinar must be notified.	Be	17. Father's Name (First, Middle, Last)	150		Ducey							
<u></u>	should ind Men i marke umatic	၉	EDWARD SCOT		19b	PUSEY Mailing Addres		AY umber or Rui		GINI. er, City o			
=	95M2		CHERYL PUSEY- DAUG		- 11	827 BRO			SBURY.		10.4		
ש	es 1 and of Health if item 27 or other tr		20a. Method of Disposition		20b. Place of	Disposition (Na y, crematory or	me of		Date		ocation - City or	Town, State	
2	Pages nent of ant: if it ary or o		1 XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			NS CEME		9/21	/2005	SAL	ISBURY.	MARYLAND	
2	permit. Pages 1 an Depertment of Heal Importent: if item 2 any injury or other ance.		21. Signature of Puna Service Licens	98 //		22. Name a	nd Address of F	acility	BOUNDS		ERAL HO		
<u> </u>	40 E # 9		Masse fe	y Hall	ely	705 1	MAIN S	STREET	SALIS	BURY	, MD 21	T	_
			23a. Part. Enter the disease, or comp shock, or heart lailure. List only	ne cause on each lin	the death. Do	not enter the mo	de ol dying, sud	ch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
, 1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	neume							2 weeks	
	Examiner			Due to (or as a	consequence	DI):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	of):		· · · · · · · · · · · · · · · · · · ·					
	and I-transit	xamlne	Cause (Disease or injury that initiated events	c									
Ŝ	se exe	ш	resulting in death) Last	Due to (or as a	consequence	ol):							
	Physician: The law requires that the death certificate be exthic cale has been signed by the attending physicien rail director, pege 2 should be detached for use as the buria	Physiclan/Medical	•	d									
Y .	rentifi ding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy						23d. Date ol de	livery	
ă	death a atter d for u	iclar	in the past 12 months?	1□Live birth : 4□Pregnant at		3 □Ectopic p 5 □ Other (s					Month	Day Year	
	by the	hys	9 Unknown	9□ Unknown									
'n	es thai	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the underlying	cause given in f	Part I.				o the cause of death?	
2	requi	Completed	avita ja	Melison	100						ILLINO SUF	robably 4 Unknov	
מ	e law has b	mple	Congest	ie Neart	· Janen	e-com	pensal	200	24a. Was		24b. Were a prior to death?	utopsy lindings availab completion of cause o	le f
<u></u>	n: Th licate r, peg								1 ☐ Yes	2 140	1 🗆 Yes	s 2 No	
=	sicia certi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/Ou	itpatient 3 D	Other		th <i>(Check only i</i> ome 5 ☐ Resi		6 ∏Othor (Cor	20(64)	
5	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injur (Month, Day			28c. Injury at Work?		28d. Describe			eny)	
5	ath. er: Aft	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day	7647	njury M	1 Tyes	2 🗆 No					
<u>"</u>	ter de irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, la . (Specify)	rm, street, facto	ry, office		28l. Location (City or To	Street an wn, State	d Number or R	lural Route Number,	
ב	pital (burs af brai D		20a Contition (III)	releian, T. th. t	é mu les suits d	death	4 - 4 4 h - 4	to act at					
	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 but safer death certificate be exwithin 24 but safer death certificate has been signed by the attending physicien To the Funeral Director. After this certificate has been signed by the attending physicien completely filled in by the funeral director, pege 2 should be detached for use as the buria	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of iner: On the basis of and manner sta	examination an	dor investigatio	a at the time, da n, in my opinion	ne and place, , death occur	, and due to the rred at the time,	date and	and manner a I place, and du	s stated. e to the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier		4	25	c. License num	nber	u	29d. Da	te signed (Mon	th, Day, Year)	
	000		* Kodney a	Wennie	W. m.	9	D	538	1	Oc	1/16/0	5	
,	7.3		30. Name and address of person who o						ev mi		1004		
	10%		RODWEY A. WENR 31. Date filed (Month, Day, Year)	104 134	4 S.D.	YISION S	1, SA	LISBUR	cy I'IL		1007		
	Sta Registr		SEP 1 9 2	2005	w &	Sport	!						

			For State	State of M	laryland /	•	rtment of H		-	giene Reg. 2.0 ()5	319	92
			Registrar 1. Decedent's Name (First, Middle,	l ast)	-	Oei	incate of t	Dealii	2. Date of De		70	3. Time o	of Death
•	Physici	an	2 2 2		Pereira	_Hon	2017		Month	Day Der 14,	Year		рМ
>	/Medic		Angell J. 4a. Facility Name (If not institution,			-11611	4b. City, Town, or	Location of Deal	-	4c. Count			
	Examin	er	321 University			331		r Spring		Mont	gome	3017	
	Funeral				ge (In yrs. last b		If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birth	hplace (State	or Foreign
	Director		578-72-4686	1 ☐ M 2 📆 F	65	Yrs.	Months Days	Hours Min.		17, 1940	1	_{untry)} inidad	1
	D.		Usuel Residence of Decedent		1								
	arylar show	_	10a. State 10b. County		10c. City, Tov	wn or Loc	cation					10d. Inside C	s 2 No
	Be-1 o	ct		omery	Silve:	r Sp							, - X
	vith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Co	untry?	
	s 23s	srai	321 University	Blvd, West			2090		Specify Ves or No	USA 14 Ba		rican Indian,	
	er de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	IS. V	Vas Decedent of H Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	Bla	ck, White		
36	hours after death with the Maryland tural; or ttems 23a or 28e-f show at Examinat must be notified at	by F	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2½ No	Specify:		Specia	⁄y:Bla	ck	
ò	2 hou	ed	15. Decedent's		168	a. Deced	ent's Usual Occupa	ation		16b. Kind of B	Business/I	Industry	
215	in 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+1	(Give I	kind of work done of OO NOT use retired	during most of wo f)	rking				
21	d with	ĕ	12	35.10 \$ (1.2 / 5.		Sec	retary			Medic	al		
p	al Hy other	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle,	, Maiden Sumai	пө)		
/lai	Wents Wents rked	To	Unknown Pereir	a				Mazie	Pereira				
Maryland 21215-0036	and l		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (Street a	and Number or R	ural Route Numbe	er, City or Town	, State, Z	ïp Code)	
Σ.	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene Them 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, The Medical Examinar must be notified at other treumatic event, The Medical Examinar must be notified at		Alpha Pereira/	Son			Playford	Lane, S		ring, M	aryl	and 20	901
ore	O T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition 1 StBurial 2 Cremation 3	☐Removal from State	remet	of Dispos	sition (Name of natory or other plac	sep	Date t. 16,	20c. Location	- City or 1	lown, State	
Ë	ment ment tent:		`4 ☐ Donation 5 ☐ Other (Spe	4	Fort 1		oln Cemet	ery 2	005	Brentwo		arylan	d
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot		21. Signature of the eral Service Lie	(am+	26	F:	Name and Addres rancis J. 30 Univer	Collination of the Collination o	s Funera vd. W. S	l Home ilver S	In prin	a. MD	20901
	-		23a. Part1. Enter the disease, or co	omplications that cause	d the death. Do							Approxima Interval Be	ite
57	Physician		shock, or heart failure. List or Immediate Cause (Final									Onset and	
	/Medical		disease or condition resulting in death)		ac Arres s a consequence						-		
	Examiner		0	b. Mvoca	rdial Tr	ıfar	rtion						
		ner	Sequentially list conditions, 1 any leaving to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	rdial Ir s a consequence	of):							
	cuted	Examin	that initiated events	C.	tes Mell		3						
0	cate be executed physicien and the burial-transit	Ë	resulting in death) Last	Due to (or a	s a consequence	of):							
8760,	ate hy	dicai		d	-								
		(a)	IF FEMALE:	220 15 400 044000	- of avanance				· · · · · · · · · · · · · · · · · · ·				-
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pregnancy				ate of deliv onth		Year
<u>o</u>	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death	2□	Other (specify)						
ď.	that the ed by detac		Part II. Other significant conditions	s contributing to death	but not resulting	in the un	derlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to	the cause of	death?
Records,	uires I sign Id be	d by	Hypertension						1 🗆 🗅	Yes 2 🙀 No	3 ☐ Pro	bably 4 🗆	Unknown
COL	w requir been si should	ompieted							24a. Was	an 24b.	Were aut	topsy findings	available
Re	The lavate has	mc								rmed?	prior to o death?	ompletion of o	cause of
		Ö	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only o		1 🗀 105	2 No	
>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐xNo	Hospital: 1 ☐ Inpat	ient 2 ER/O	utpatient	3□ DOA Othe	200	lome 5 ⊋Resid		ner (Spec	ify)	
		n; T	27. Manner of Death	28a. Date of Inj (Month, D.	ury 28b.	Time of Injury	28c. Injury Work	at		now injury occur		,,,	
<u>0</u>	Attending I r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	tion	-,	,,		Yes 2 □ No					
Division		Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 286. Flace of It	njury - At home, f etc. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (5 City or Tox	St reet and Numl vn, State)	or Rui	ral Route Num	nber,
	itel o rs aft ral Di led in			4					,				
	To the Hospitel or within 24 hours afte To the Funeral Dire completely filled in I	edical		Physician: To the bes aminer: On the basis and manner s	of examination a								s)
	To th withir To th comp	Me	29b. Signature and title of certifier	051			29c. License	number	6	29d. Date signe	d (Month	, Day, Year)	_
	·ī		► 1160	V the	_		1)4	177	7	9.1	5.	50 OZ	>
	(30. Name and address of person wh										
	Sta	to	Jack Richard : 31. Date filed (Month, Day, Year)	Epstein, M. 32/Regist	. บ. 108 trar's Signature	210 (Connectic	ut Avenu	ie, Kens	ıngton,	MD 2	:0895	
	Registr	-		2005	trar's Signature	B 100							

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of N	/laryland		artmen rtificat			nd M		jiene	005	5 3	319	94
Physicia		Decedent's Name (First, Middle, Las Oscar Palini	t)							2. Date of Dea Month Septembe	Day		ear	3. Time o	- M
/Medic Examin		4a. Facility Name (If not institution, give		-	2		Town, or	Location of		эсресию	4c.	County of	Death		,
Funeral Director		5. Social Security Number 6. Se 230-50-9162		nouse age (in yrs. ia 74			1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day May 25	Year)		. Birthpl Count	ace (State	or Foreign
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgot	mery		Town or Lo								10	ld. Inside 0	City Limits
or 286	Director	10e. Street and Number				10f. Zip				1	l0g. Citiz	zen of Wha	at Count	ry?	
s 23e		5801 Foggy Lane	12. Was Deceder	t Ever in II S	13.1		0855	nanic Orig	in? /Spe	city Yes or No-		4. Race -	JSA America	n Indian	
filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23e or 28e-f show ent, the Marical Examiner must be notified at	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	?] No		f Yes, spe	cify Cubar	Specify:	Puerto F	Rican, etc.)			White, e	tc.	
permit. Pages 1 and 2 should be filed within 72 ho Department of Heatin and Mental Hygiene. Importent: If Item 27 is marked other then "neturenty injury or other treumetic event, It is Michael once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4o	r 5+)	life. l	kind of wo	rk done d se retired)	uring most		9		nd of Busin		ŕ	
filed Hygid other ent, i		17. Father's Name (First, Middle, Last)	4		Engin	eeri	_			(First, Middle,		ellit Sumame)	e Te	estin	g
Aental Aental rked c	To Be	Francesco Palin	Ĺ					Geno	veff	a Tacco	oni				
2 should I and Meni Is marker reumetic		19a. Informant's Name/Relationship (7								Route Number					
1 and Health em 27 wher tr		Gemma L. Palini/	Wife	20h Pla	580 Ice of Dispo			ane,		ville,					
Pages nent of H		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from Stat	e cei	metery, creri	natory or c	ther place	, , ,		20,		antow			and
permit. Departm tmporte eny inju		21. Signature of Funeral Service License	Cams	ey	22 F	. Name ar	d Address	of Facility	ins	Funeral	Ног	ne In	.c	- 5	
Physician /Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	tic Br s a conseque s a conseque s a conseque	ence of):	al Ad	lenoc	arcin	oma						
ate the	edical		d												-
The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal c	death 3 [Ectopic pr Other <i>(sp</i>					2	3d. Date of Month			Year
w requires that i been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												cause of	
	Completed							_		24a. Was a autops perform	v	prior deat	to com	sy findings pletion of d	available cause of
sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor			(Check only on					
Hospitel or Attending Physicien: 44 hours after death Funerel Director: After this certific tely filled in by the funeral director,	ation: To	1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	1 □ Inpa 28a. Date of In (Month, D	jury 2	R/Outpatien 28b. Time of Injury		8c. Injury Work	4 🗀 1901:	2	e 5 Reside 8d. Describe ho			Specify)	Hosp:	ice
To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification	3 Suicide 6 Could not be 4 Homicide determined	No.	etc." (Specify)						8f. Location (St City or Town	i, State)				nber,
e Hosp 24 hou e Funer letely fill	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the besiner: On the basis and manner:	of examination	ledge, death on and/or inv	occurred estigation	at the time in my opi	a, date and nion, death	place, ai occurre	nd due to the ca d at the time, da	ause(s) a ate and p	and manne place, and	r as sta due to t	ted. he cause(s	s)
	Me	29b. Signature and title of certifier	Her			290	License	number	18	. 2	9d. Date	signed (M	fonth, D	ay, Year)	
5		30. Name and address of person who of Charles Harrison,					レ / 11 R/	nad.	Rock	ville,	MD 2	0855)	
Sta Registr		31. Date filed (Month, Day, Year) SFP 1 9 20		trar's Signatu		ale i		-uu, .	LOCK.	v 111E,	. IU Z	.0033			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene o or

					Certificat	e of Death		Reg. No.	15 3	11995
	Physici /Medi		Decedent's Name (First, Middle, Las Pauline Theresa Pe	ellet			2. Date of De Month Sept 2:	Day 2005	Year 7	3. Time of Death
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give Goodwill Mennonite 5. Social Security Number 135–32–4294 Usual Residence of Decedent	e Home	st birthday) If Under Months		ville		Garret	t e (State or Foreign
	show	'n	10a. State 10b. County Maryland Montgo	-	Town or Location Montgomer	v Villago			10d.	Inside City Limits 1 ☑ Yes 2 ☐ No
	with the N 3a or 28a-f	I Director	Maryland Montgo		10f. Zip			10g. Citizen of \	What Country	
020	3 within 72 hours efter death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☼ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 3☐ No If Yes, Give Year or Dates:		dent of Hispanic Origin? () cify Cuban, Mexican, Puel 2 ² No <i>Specify</i> :	Specify Yes or No nto Rican, etc.)	5- 14. Rac Blac Specify	ce - American ck, White, etc. White	
Maryland 21215-0020	77 5 2 10	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wo life. DO NOT us Registered	rk done during most of wo se retired)	orking	16b. Kind of B	usiness/Indusi	
yland	lould be filed I Mental Hyg Parked other Instic event,	To Be C	17. Father's Name (First, Middle, Last) John Vasisko			18. Mother's Na	me (First, Middle Hakos	, Maiden Surnan	7 8)	
Baltimore, Mar	Pages 1 and 2 should ent of Health end Mer it: If item 27 Is marke iy or other traumstic		19a. Informant's Name/Relationship (T) William J. Pellet 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Son 20b. Plan State	525 Cape A ce of Disposition (Nar netery, crematory or d	Anne Place, me of ther place) Lery, Sept.2	Montgome Date	ery Ville 20c. Location -	age, Mi City or Town,	D 20886 State
Baltii	permit. Pag Department Important: II any injury o		21. Signature of Funeral Service Licens	emac	22. Name an 179 Mi]	d Address of Facility N	ewman Fu Box 275,	neral He Grants	omes, 1	P.A.
1	Physician /Medical Examiner	.	23a. Part 1. Enter the disease, or dompi shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	CONGEST	IVE H	EART F	AILUG	LE	On	proximate erval Between nset and Death
68760,	es that the death certificate be executed igned by the ettending physician end be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	CORONA	s a consequence of): LY H s a consequence of): HR Y H	OINTERY YPERTE	DISE	eedin 4sE	8	MONTH MONTH MONTH
P.O. Box	nat the death cel d by the ettendir Jetached for use	by Physician/	Part II. Other eignificent conditions con	ntributing to death but not resulti			23b. Did	tobecco use cor	ntribute to the	e cause of death?
Vital Records,	w requir s been s should	Completed by	RENAL I	NSUFFIC	IENCY			an autopsy rmed?	availab	autopsy findings ble prior to etion of cause th?
tal F		Be Cor	25. Was case referred to medical			26. Place of De	1 ☐ 1	Yes 2 No	1 □ Ye	es 2 Z N o
Ξ	hyslcie his cer il direc	10 B	I Tes ZIA NO	fospital: 1 ☐ Inpatient 2 ☐ EF		Other: 4 Nursing H	forme 5□ Resi		er (Specify)	
Division of	ling Afte fund	Certlfication:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hom	М	8c. Injury at Work? 1 ☐ Yes 2 ☐ No		now injury occurr		uste Number
<u>≥</u>	5 # 5 €		4 ☐ Homicide determined	building, etc. (Specify)			City or To	vn, State)		
	To the Hospitel or within 24 hours efter To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one)	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred n and/or investigation,	at the time, date and place in my opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated and due to the	I. cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	D Da . 4.11		License number		29d. Date signed	(Month, Day,	Year)
			1 Wallahau IV	MULLUNI / MI	1	7 2 2 0 0)	7122	10.5	

12 State

Sabahat Nawab, 32 Corporate Drive, PO Box 265, Grantsville, MD 21536 31. Date filed (Month, Day, Year) SEP 2 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

		For State Registrar	State of	Marylan		artment of <i>rtificate of</i>			al Hygien	เบบอ	31996
Physic /Medi		Decedent's Name (First, Middle, G.	Last) lenn	Edward	l Pá	renteau		Mo	te of Death onth Da otember	y Year 25 2005	3. Time of Death 2:03 A M
Examir		4a. Facility Name (If not institution, Frederick Memo				4b. City, Town, Frede:		of Death	40	County of Death	ck
Funeral Director		5. Social Security Number 578 - 34 - 4189		. Age (In yrs. 7 7		If Under 1 Yea Months Days		Min. (Mo	le of Birth onth, Day, Year, il 19,	9. Birth Cou 1928 Wash	place (State or Foreign ntry) nington, DC
Maryland	tor	Usual Residence of Decedent	rick		y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🙀 No
th the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
ath wi		8321 Edgewood C	,			217				U.S.A.	
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 TYPes 2 If Yes, Give Year or Dat	es? □No 19 5	51-	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕱 No			etc.)	14. Race - Ameri Black, White Specify:	
21215-0036 od within 72 hours at giene. er then "natural, or the Madical Exam.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12		4or 5+)	(Give life.	dent's Usual Occi kind of work done DO NOT use retir	e during mos ed)		16b. K	and of Business/ir	ndustry
e filed other	BeC	17. Father's Name (First, Middle, L	ast)	-				er's Name (First,	Middle, Maider	Sumeme)	
arylan should be ind Mental in marked o	To B	Edward Par	renteau				Ros	se Marie	Porter		
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth r traumatic event	14	19a. Informant's Name/Relationsh	_		19b. Maili	ng Address (Stree	at and Number	er or Rural Route	Number, City	or Town, State, Zi	o Code)
Nore, Nores I and of Health if Item 27 or other to		Myrtle B. Parent 20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from S	tate	Place of Dispo emetery, crea	osition (Name of matory or other pl	ace)	Date	20c. L	crick, MI	own, State
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic avonce.		4 Donation 5 Other (Sp 21. Signature of Funeral Service L		Mr.	2:	et Cemeto 2. Name and Addi eeney and	ress of Facili	•		106 East	Maryland Church Street k, MD, 21701
Physician /Medical Examiner be executed Examiner bhysician and street physician and street physician street	dicai Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) saqualitation of the cause (Final disease). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	used the death challed the line. CALLET ras a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a conse	uence of):	er the mode of dy	ring, such as	cardiac or respii	ratory arrest,		Approximate Interval Between Onset and Death
Geath certif	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnan Other (specify)	су			23d. Date of delive	ery Day Year
	d by Ph	Part II. Other significant condition	ns contributing to dea	ith but not resi	ulting in the u	nderlying cause g	iven in Part I	. 23	e. Did tobacco		he cause of death?
Division of Vital Records, P.O to Attending Physician: The law requires that the effer death. Director: After this certificete hes been signed by the in by the funeral director, page 2 should be detached in by the funeral director.	Completed								a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of 2 No
of Vital F Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	20%	1 in	0	ther	of Death (Chec			
Division of Vita Vita No Physician: to the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	ıtlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of (Month	-	28b. Time o Injury	28c. Inju	4 🗆 140	28d. De	Besidence inju	6 Other (Special of the Control of t	(y)
Division allor Attending s efter death. al Director: After	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place C	f Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory, office		28f. Loc City	cation (Street ar y or Town, State	nd Number or Run a)	al Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	edicai (Physician: To the becaminer: On the base	is of examinat							
within To th compl	Me	29b. Signature and title of certifier	Λ.			29c. Licer	se number			te signed (Month,	Day, Year)
	l li	Seeth	Holler	ul W	W	102	166	09	9/	22/05	
6		30. Name and address of person was Joseph Ashwal,					Freder	ick Mo	rvland	21702	
Sta Regist		31. Date filed (Month, Day, Year)		gistrar's Signa		West .	Cuc1	. row, ma	- y 1 and ,	21.02	

			For State Registrar	State of M		epartment of Certificate of		ınd Mental Hy	ygiene Reg. 2 2. () (15 31997
	Physicia	an	1. Decedent's Name (First, Middle, Las		PRICE			2. Date of D Month	eath Day	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give			4b. City, Town	, or Location o		mber 14 4c. County	
		<u>.</u>	Washington Adve				a Park		Montg	•
	Funeral Director		5. Social Security Number 6. S 577-56-9960	ex 7. A ⊠M 2□ F	ge (In yrs. last birt	hday) If Under 1 Ye rs. Months Da		Min. 8. Date of B (Month, C Janua	lay, rear)	9. Birthplace (State or Foreign Country) Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		<u>.</u>		10d. Inside City Limits
	Mary I-f sho	tor	MD Prince	George's	Нуа	ttsville				1X Yes 2 No
	or 28s	Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of	•
	sath w	erai	4514 Burlington R	load 12. Was Deceden	Ever in U.S.	2078		nn? (Specify Ves or N	U.S.	A .
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Examinar must be recitized at	by Funerai	11. Marital Status 1 ★Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 N If Yes, Give Year or Dates:	?	If Yes, specify 0		gin? (Specify Yes or N , Puerto Rican, etc.)	Bla Specif	ck, White, etc.
5-0	72 hou	eted	15. Decedent's Ec (Specify only highest gra		16a.	Decedent's Usual Oc (Give kind of work do	ne during most	of working	16b. Kind of B	usiness/Industry
Maryland 21215-0036	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Contracto	ired)		Priv	ate
od 2	be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, Last)		I			r's Name (First, Middle		
ylaı	2 should be and Mental Is marked or aumatic ev	To E	James W. Price					Stewart		
Mar	d 2 sh th and th srr traum		19a. Informant's Name/Relationship (7) Betty E. Corbett/			-		ror Rural Route Numi ad Hvattsv		State, Zip Code)
re,	os 1 and 2 of Health i item 27 l		20a. Method of Disposition		20b. Place of	Disposition (Name of		9/16/05		- City or Town, State
Baltimore,	Page ment c ant: If ury or		1 ☐ Burial 2 XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		•	lale Crema	tory			ale,Maryland
Balt	permit. Pages 1 Depertment of H Important: If ite any injury or ot once.		21. Signature of Funeral Service/Licen	hal	0			J. B. Jen oad Landov		neral Home vland 20785
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Can Due to (or a b. Arleri	a consequence of a consequence of	loma cardis		west above		Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	fedicai Examiner	resulting in death) Last	c	s a consequence o)f):				
.O. Box	that the death certifics ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify,				te of delivery onth Day Year
ds, P.	se ign	by	Part II. Other significant conditions o	ontributing to death	but not resulting in	the underlying cause	given in Part I.		tobacco use cont	tribute to the cause of death?
Vital Records,	The law ate has b page 2 s	Completed						24a. Wa auto perf 1 \(\text{Yes}	opsy formed	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ent 2 ER/Out	patient 3 DQA	Othor	of Death (Check only sing Home 5 Res		
J Of		\vdash	27. Man of Death	28a. Date of Inj (Month, D	ury 28b. T	ime of 28c. In	jury at		how injury occur	
sior	Attending r death. ector: After yot the fune	catio	1 V atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	□Yes 2□N			
Division	in the	Certification:	4 Homicide determined	280. Place of it	jury - At home, far tc. (Specify)	m, street, factory, offi	C8	28f. Location City or To	(Street and Numb own, State)	per or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the bes niner: On the basis and manner s	of my knowledge of examination and tated.	, death occurred at the d/or investigation, in π	time, date and y opinion, deat	d place, and due to the h occurred at the time	cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
)	To the vithin comp	M	29b. Signature and title of certifies	mi M.	D	29c. Lica	1889	5	29d. Date signe Septemb	anner as stated. and due to the cause(s) d (Month, Day, Year) AN 15, 2015 AD 20912—
R	(3)		30. Name and address of person who MOBARAK KAR	completed cause of	death (Item 23a) (Type, Print) Awwe, S	te 340	, Takon	Park, 1	1020912
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 9 200	5 Regist	rar's Signature	parte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per vife 859 9-8-06 vt. State of Maryland / Department of Health and Mental Hygiene 0 0 5

			1 - For State Registrar			,	Cen	tificate of	Death	7	R	Reg. No.					
	Dhysici	an	1. Decedent's Name (First, Mic	dle, Last)							2. Date of Dea Month	nth Day Year					
	Physici /Medic		JEROME		PROCT	OR					SEPT.	. 14, 2005 2245			P M		
}	Examin	er	4a. Facility Name (If not institut 1201 BENNING		4			4b. City, Town, CAPIT	OL HE	IGHTS		PF	Inty of Death	GEORGES	S		
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age (In yrs. last birt 33	hday)_ Yrs.	Months Day		Min.	8. Date of Birth (Month, Day		Co	hplace (State o			
	Director		579-94-2806 Usual Residence of Decedent			33				May 29	1972 Washington, DC						
	ylanc		10a. State 10b. Coun	ty	1	0c. City, Town	or Loc	ation						10d. Inside Ci			
	e Ma	cto		ce George'	s	0xoı	n Hi	111						1 X Yes	2 🗌 No		
	h with th	al Director	10e. Street and Number 2228 Alice Av	venue # 10	1			10f. Zip Code	20745			-	Og. Citizen of What Country? U.S.A.				
	death	ner	11. Marital Status	12. Was Dec	cedent Eve	er in U.S.	13. W	/as Decedent of	Hispanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	rican Indian,			
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "neture!", or Items 23a or 28a-f ehow or other traumatic event, the Medical Examinational be notified at	by Funeral	TENever Married 2 M. 3 □ Widowed 4 □ Divorce	arried 1 Tes	2 X No ive			☐ Yes 2X No				ì	Specify: Black				
5-0	"netu	Completed		ent's Education lest grade completed)	16a.	Decede	ent's Usual Occi and of work don O NOT use retir	pation during mo	st of worki	ing	16b. Kind o	f Business/I	Industry			
121	within ene. than "	ďω	Elementary/Secondary (0-12) College	(1-4or 5+)	C		old Bui				τ	Privat				
d 2	Hygie Hygie other		10th 17. Father's Name (First, Middl	e, Last)			all	ora bur	7	ner's Name	Maiden Sum		.е				
lan	Mental Mental arked c	To Be	Nelson Da	niels													
Maryland 21215-0036	d 2 should be th and Mental 17 is marked traumatic ev		19a. Informant's Name/Relatio Mary Chase	nship <i>(Type, Print)</i> /Mother					I Route Number	-			745				
Je,	ges 1 and 2 it of Health if Item 27 or other tr		20a. Method of Disposition		ition (Name of atory or other pl	ace)	D	Date	20c. Locatio	on - City or 1	Fown, State						
Ë	Pages ment of ant; If it ury or o	1 5	1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other		State	Resur	surrection 9/22/05 Clinton, Maryland										
Baltimore,	permit. Page Department Important; If any Injury or once.		21. Signature of Funeral Servi	e Licensee	00		22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785										
	HO = W W		23a. Part1. Enter the disease,	or complications that	caused the	e death. Do n						Tand	Approximate	θ			
	s		shock, or heart failure. Li Immediate Cause (Final	st only one cause on	each line.	JL	1	2	11/	- / No	J 41,		Interval Bet Onset and E	ween			
	Physician /Medical		disease or condition resulting in death)	a	(or as a c	onsequence	of):	5 0 W	T81-4	000	unds						
	Examiner		Sequentially list conditions	b			,										
	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a c	onsequence	of):										
	death certificate be executed e attending physicien and d for use es the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a c	onsequence	of):										
68760,	ysicier ysicier			d													
	ng ph	Medical	IF FEMALE:														
Box	eath ce attendi for use	lan/I	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death		Ectopic pregnan	су				Date of delive Month		/ear		
o.		Physician/	1 □ Yes 2 □ No 9 □ Unknown	4□Preg 9□Unkr		ne of death	5 🗆 .	Other (specify)									
Δ.	requires thet the een slgned by th hould be detache	by PI	Part II. Other significant condi	tions contributing to	death but n	not resulting in	the und	derlying cause g	iven in Part	I.	23e. Did tot	acco use co	ontribute to	the cause of d	eath?		
orde	w require been signations of the should be										1 □ Ye	s 2No	3 Pro	obably 4 🔲 U	Jnknown		
Division of Vital Records,	aw 2 si b	Completed									24a. Was a autops	у	b. Were aut	topsy findings a	available ause of		
E H											perform Yes 2		1 Yes	2□ No			
Vite Vite	Physician: The this certificate ral director, pag	Be	25. Was case reterred to medic examiner?	Hospital:		-5			4		(Check only on			A.T. O.	NEW IEE		
ō	Phys r this ral di	. To	1√ Yes 2 No 27. Manner of Death	1	Inpatient of Injury oth Day Y	2 ER/Out		3 DOA 28c. Inju	4 L IV	-	ne 5 ☐ Reside			My) AT SC	JENE		
ion	Attending Phyrideath.	Certification:	1 Natural 5 Pend 2 Accident inves	ling (Moi	1 Day Y	ear) 25	LY 3		ork?]Yes 2 / ≹	/	Sulsi	ect	8/2	8t			
Vis	or Atten efter deat Director: in by the	tifica	3 ☐ Suicide 6 ☐ Coul	mined 200. Flac	e ot Injury ling, etc. (- At home, far	m, stree	et, factory, office)	2	28f. Location (St. City or Toyn)	reet and Nu	mber or Rur	ral Route Numi	ber,		
Ö	Ital or irs efte ral Dir led in	Cer			inig, oto. (t	TOPK	in	5 /OT		/	201 8	envin	3/4D				
	To the Hospital or Attan within 24 hours efter deati To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certify (Check only one)	ring Physician: To the at Examiner: On the tand man	e best of no casis of ex oner stated	amination and	death of	occurred at the sastigation, in my	ime, date a opinion, de	nd place, a ath occurre	and due to the cand at the tiple, d	use(s) and ate and plac	manner as er ariddue	stated.	0		
	To the within 2. To the complet	Me	29b. Signature and little of certif	ier					ise number		2	od. Date sign	ned (Month,	Day, Year)	<i>y</i>		
)			Clay	em)				C.M.E			SEPT.	15,	∠UUЭ —			
R	-(2)		30. Name and address of person	OCKE, A	10				BALT	IMORE	, MARYLAI	VD 212	.01				
	Sta Registr		31. Date filed (Month, Day, Yea	de													
			V 161 4		ALLAND		A STATE OF THE PARTY OF THE PAR	-									

KARL RICHARD PETERSON Unknown 05-05806 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 28 Kar1 Richard Peterson 2005 7:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11950 Clopper Road Germantown Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**M** M 2□ F New York Yrs. 39 Director 070-42-2860 21, 1966 Mar Usual Residence of Decedent the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23s or 17732 Caddy Drive 20855 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Electronics Manufacturer t. Pages 1 and 2 should be filed witnest of Health and Mental Hygie stant: If Item 27 is marked other figury or other freumatic event, ID. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman C. Peterson Ruth Maxine Fierst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman C. Peterson/father 17732 Caddy Drive Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September permit. Pages:
Department of H
Important: If Ite
eny injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 19, 2005 Odenton, Mayland 21. Signature of Funeral Se Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rowning resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Mospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Physician/Medical ettending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an page 2 s autopsy performed? certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence (Specify) at Scene Certification: To 2 ER/Outpatient 3 DOA tuneral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. investigation LLUKNOWA unknown i Director: / 2 Accident Unknown Could not be determined 3 🔲 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Benera Stak Pank 950 Clopper Rd Germantown, MP 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours efter To the Funerel Dir found in creek 11950 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. August 29, 2005 pleted cause of death (Nem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 strar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

20

2005

Division of Vital Records, P.O. Box 68760,

			For	, 104	State	of Maryla						-	_ ,	0000	0000	
	755		State Registrar	ame (First, Middle	(ast)	_	Ce	піпса	te of L	Death		2. Date of De	Reg. No	2005	3. Time of Deat	LU
	Physici			ald Alfr								Month	Day	18 2005	5:54 P	М
}	/Medic Examin	-	4a. Facility Name	e (If not institution,	give street and r	umber)		4b. City	, Town, or	Location of	of Death			County of Death		
	* *	-C.		rick Mem				F.	eder	ick If Under		Frederick				
*	Funeral		5. Social Security 215-02-		6. Sex 1 ∰ M 2 □ F	7. Age (In yrs.	. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)	Cou	place (State or For intry)	eign
	Director		Usual Residence			30						Jan. 10	o, 19	969 Phil	lippines	
	how		10a. State	10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Lin	
	8a-f	Director	Maryland		lerick		Fred	erick	D Code				10- 04	zen of What Cou	1 ⊠ Yes 2 □	140
	with t		10e. Street and I						1701							
	death	Funeral	11. Marital Statu	rren Way s	12. Was De	cedent Ever in U	J.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		ited Sta 14. Race - Amer Black, White	ican Indian,	
9	or tte	y Fu		arried 2 🔀 Marri	ed 1 TYes	a 2 ☑ No Give]	1		Specify:		rican, etc.)		Specify: B1		
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "natural", or Iteme 23a or 28a-f ehow event, it a Madical Examinal must be notified at	ed by	3 ∐ Widowed	d 4 Divorced	Year or	Dates:	16a. Dece	dent's He	ial Occupa	ation			16b Ki	nd of Business/I		
7	in 72 n "na	Completed		pecify only highes econdary (0-12)	t grade complete	(1-4or 5+)	(Give	kind of w	ork done d	turina mos	t of work	ng	100.10	114 01 0431116331	loustry	
N	d with	mo mo	Clementary/3	scoridary (5-12)	College	2	Inter	net I	echn					puter S	cience	
nd	be filed value Hygie of other levent, It	Be		n <i>e (First, Middle, l</i> Maurice								e (First, Middle,				
Maryland	2 should be and Mental le marked aumatic ev	ဥ		Name/Relationsh			19h Maili	na Addres	s (Street a			Elaine		r Town, State, Z	n Code)	
	lth an 27 ie r			ay / Wif								rick, M			p 0000)	
J.	os 1 au of Hea itam r othe		20a. Method of D			20b.	Place of Dispo cemetery, cre					Date 23,		cation - City or T	own, State	
Ē	Pages ment of I ant: if its ury or o			2 Gremation on 50 Other (St		n State	sthaven				-	005	Fre	derick,	Maryland	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Itam 27 ie marked any injury or other traumatic e 2008.		21. Signature of	Financia Service L	icensee		R	2. Name a estha	nd Addres	s of Facilit	al S	ervices	s, Sk	kot Cod	y P.A.	
	auzea		23a Par Ente	ef the disease, or neart failure. List	complications tha	t caused the dea	th Do not en	501 C	atoc	tin_M	cardiac o	Hwy Fr	reder	ick, MD	21701 Approximate	
	Discontinuo		shock, or h Immediate Caus		/ : .						_				Interval Between Onset and Death	١ _
	Physician /Medical		disease or cond resulting in deat		-	O (or as a conse		حاساك	11	ING	CA	RUNON	74-		II MONT	KS
SY	Examiner		Sequentially list	curottions.	ь											
	ed sit	Examiner	Sequentially list if any, leading to cause. Enter Ur Cause (Disease	ndertying 🚄	Due t	o (or as a conse	quence of):									
	te be executed ysicien end le burial-transit	xan	that initiated eve resulting in deat	ents	c. Due t	o (or as a conse	quence of):	-								
760,	icate be executed physicien end s the burial-transit	call			d											
89	artifica ing ph e as th	Med	IF FEMALE:								-					
Вох	leath certific attending p	lan/	23b. Was deced in the past	12 months?	1 ☐ Live	outcome of pregre birth 2 DFet gnant at time of	al death 3	□Ectopic p					4	23d. Date of deli- Month	ery Day Year	
o.	that the death cer ed by the attendin detached for use	Physician/Med	1 ∐ Yes 9 ☐ Unkno		o Uni				pacity)							
ď.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by PI	_	nificant conditio	ns contributing to	death but not re	sulting in the u	ındərlying	cause give	en in Part I		23e. Did t	obacco u	se contribute to	the cause of death	
ord	w require been sig should t			NONE								10	Yes 2[⊒No 3∏Pro	bably 4 Unkno	own
Vital Records,	elawi hasbu je 2 sh	Completed								. -		24a. Was autop		24b. Were aut prior to o death?	opsy findings available ompletion of cause	of
<u>a</u>	ician: The li certificate ha rector, page		DE Was case ro	eferred to medical	2					00 Pl	- (D **	1 ☐ Yes	2 No	1 ☐ Yes	2 No	_
	ysician: is certific director,	To Be	examiner?	PNo	Hospital:	⊒!npatient 2 🖸	R/Outpatie	nt 3□ □	OA Othe	or		n <i>Check only o</i> me 5 □ Resi		3 □Other (Spec	fv)	-
0	g Ph		27. Manner of D	eath 5 □ Pending	28a. Dai	e of Injury onth, Day Year)	28b. Time o		28c. Injury Work			28d. Describe				
Sio	tendin death. tor: Afi the fur	catle	2 Acciden	nt investig	ation ot be			М		Yes 2□		00(1)	01		18	
Division of	2 8 5 E	Certification:	4 ☐ Homicio	datami	ned 288. Pla	ce of Injury - At I Iding, etc. (Spec	nome, farm, st ify)	reet, facto	ry, office			City or To			al Route Number,	
_	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier	1 Certifyin	g Physician: To t	he best of my kn	owledge, deat	h occurre	d at the tim	ne, date an	id place,	and due to the	cause(s)	and manner as	stated.	
	the Ho in 24 lihe Fu the Fu	Medical	(Check only one)	-2	Examiner: On the and ma	basis of examin anner stated.	ation and/or in				th occurr				* 1	
		2	29b. Signature a	and title of certifler		MD			c. License		711			e signed (Month	Day, Year) 8, 2005	
	6		20 Nom a == 1	Haraca of a	who completed		m (3a) /T		1000	56	314		۱۲ اب		-, 2003	
	'		BINDU	ddress of person of GEORGE	, 46 B	THOMA	S JOHN	150N	DRII	/E , 1	FRET	ERICK	M	D 2170)	
22	Sta		31. Date filed (M	Nonth, Day, Year)	A 2005	Registrar's Sign	ature									
-A-12	Registr	rar		OLI K	0 2003	alletue	, the	does	1/1							